			For State (•	artment of Health and rtificate of Death		ene 	31501
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ellwood C G	oodrich		2. Date of Death Month	Day Year	3. Time of Death 5. 49Am
	Examin		4a. Facility Name (If not institution, give street and not the street		4b. City, Town, or Location of Dea	rs	4c. County of Death Ame A	Frundel.
L.	Funeral Director		5. Social Security Number 216-36-0806 Usual Residence of Decedent	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		year) 9. Birthpl Coun 1939 Mary	lace (State or Foreign try) yland
	Maryland	tor	10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Lo			10	0d. Inside City Limits 1 ☐ Yes 2 🗖 No
	h with the 13a or 28a 11 be noti	Funeral Director	10e. Street and Number 604 A Street		10f. Zip Code 21122	109	g. Citizen of What Coun	try?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Endminer must be notified at	þ	Armed F	orces? 2 No live	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Americ Black, White, of Specify: Wh:	
21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 12	(Give (1-4or 5+)	dent's Usual Occupation kind of work done during most of w DO NOT use retired) IPERVISOR		BG & E	lustry
Maryland 2	ould be filed withi Mental Hygiene. arked other than atic event, n. M	To Be Co	17. Father's Name (First, Middle, Last) Elmer Goodr:		18. Mother's N	ame (First, Middle, Ma		
	1 and 2 should Health and Men Iem 27 is marke		19a. Informant's Name/Relationship (Type, Print)		ng Address <i>(Street and Number or I</i> Street, Pasaden	a, Marylar	nd 21122	
Baltimore,	Page nent o ant: if ary or		20a. Method of Disposition 1	n State	osition (Name of matory or other place) In Mem Gardens 10		Oc. Location - City or To Marriottsvi	
Balt	permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service Licensee	MC MC	2. Name and Address of Facility Cully—Polyniak F 204 Mountain Road	uneral Hon , Pasadena	ne P.A. a, Maryland	21122
7-4	Physician /Medical		233 Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not en each line. Uemonica of (or as a consequence of):	ter the mode of dying, such as cardi	ac or respiratory arres	51,	Approximate Interval Between Onset and Death
8760,	ate be executed bysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to home diata cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequence of):				
.O. Box 6	that the death certific ted by the attending p detached for use as i	Completed by Physician/Med	230. Was decedent pregnant 1 Live	gnant at time of death 5 [Ectopic pregnancy Other (specify)	-111	23d. Date of delive Month	ery Day Year
٥.	w requires that to be a signed by should be detail	ed by Ph	Part II Other significant conditions contributing to		underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
I Records,		Complete				24a. Was an autopsy perform	ed? prior to condeath?	psy findings available mpletion of cause of
Vital	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	Other	eath (Check only one) nce 6 ☐Other (Specifi	
ion of	> .00	ation: To	27. Manner of Death 28a. Dat	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe hov		0
Division	5 # G	Certification:		ce of Injury - At home, farm, si Iding, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
	Hospital 24 hours Funeral etety filled	edical	(Check only 2 Medical Examiner: On the	he best of my knowledge, dea basis of examination and/or in anner stated.	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner as st te and place, and due to	tated. the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	20 ms	29c. License number	2	d. Date signed (Month,	Day, Year)
1	3/1		30. In the and address of person who completed ca	use of death (Item 23a) (Type MOLXO	- 2001 MEDIC	Ah PRU	y AND	AFONE
	St Regist	ate rar	31. Date filed (Month, Day, Year) 6 2004 32	Redistrar's Signature	Sperke			

			1 - For State Registrar	State of	Maryland		artment of I	Health and M Death		giene Reg. No. 0 0	1 3	502
	Physici /Medio Examir	al	Decedent's Name (First, Middle, L Edna L. Grove Aa. Facility Name (If not institution, g		ber)		4b. City, Town,	or Location of Death	2. Date of Dea Month	Day	Year 4	ime of Death
	Funeral		Franklin Squ. 5. Social Security Number 6.	Sex 7	38/1+0 '. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	Boly	time	State or Foreign
	Director		213-34-7954 Usual Residence of Decedent	1□M 2 X F	88			Flours IVIII.	03/18/1	916	Maryla	
	e Marylar 3a-f ehow illied at	Director	10a. State 10b. County MD Baltin	more		Town or Lo						side City Limits ☐ Yes 2X No
	death with the Maryland ms 23s or 28s-f show f must be notified at	eral Dire	10e. Street and Number 3807 Schroeder				10f. Zip Code 2112			U.S.A		
036	urs after de al', or Item Exeminar	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Fore	2 [X No		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:	- American Inc , White, etc. White	dian,
215-0	within 72 ho ene. then "natur he Madical I	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Bus		
Edno-Maryland 21215-0036	d be filed wantal Hygier ted other th	Be	17. Father's Name (First, Middle, Las	st)		Hom	emaker	18. Mother's Nam				
Mary	d 2 should th and Me ?7 ie mark traumatic	J.	Frank Eisner 19a. Informant's Name/Relationship					and Number or Rui		r, City or Town, S		
$G f_{OV}$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.		Lois Micucci ((20a. Method of Disposition 1	□Removal from S	tate	ace of Disponentery, creme kwood	sition (Name of matory or other pla Cemeter	ce)	5/2004	20c. Location - C	city or Town, S	vland
8	9 9 E 8 9	ista	23a. Part1. Enter the disease, of co shock, or heart failure. List on	mplications that ca	used the death.	1	1750 Bela	air Road	- Kingsv	ville, Ma	ryland	21087 oximate val Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	.a. sef	SiS or as a conseque	ence of):						and Death
	Examiner and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque							
8760,	icate be executed physicien and s the burial-transit	dical		d	or as a conseque	ence or):						
.O. Box 6	that the death certificated by the attending placed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 Fetal on the at time of dea	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery h Day	Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions Preumonio,	JIBle	eth but not resul	ting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contrib es 2 ☑No 3		se of death?
al Reco	The law ate has b page 2 si	Completed by							24a. Was a autop: perfor 1 Yes	sy pri med? de	ere autopsy fir or to completion ath? Yes 2 1	
) Division of Vital Record	Attending Phyelcien: The Ir death. c death. ector: After this certificate hay the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of (Month		R/Outpatier 28b. Time of Injury	28c. Inju	ry at	ome 5 Resid	ence 6 ⊡Other ow injury occurred		
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	288. Place	of Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Rout	e Number,
	he Hospil in 24 hour he Funeri pletely fills	edicai	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex	Physician: To the laminer: On the ba and mann	sis of examination	rledge, deatl on and/or in	occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the c red at the time, c	ause(s) and manifate and place, an	ner as stated. Id due to the c	ause(s)
	To t To t Com	Z	29b. Signature and title of certifier	ali	, MD,	PhD	29c. Licen:	se number		29d. Date signed	(Month, Day,)	(ear)
_	V		30. Name and address of person who Dr. Hossein Arde	o completed cause		1 ==		repriv	77	timose	MP	21237
	Sta Registi		31. Date filed (MOC Tay 0°6) 2	32. F	distrar's Sign to	Ire &	Spark				7	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28, September Physician WILLIAM GEORGE GRENIER, JR. 2004 5:08 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Year) 11 M 2□F 213-58-9747 54 Director 1950 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 8383 Sweet Cherry Lane 20723 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ※XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married XX Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 💥o Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vice President Citizens National other treumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fi Health and Menta! H tem 27 is marked otl William George Grenier, Sr. Alice S. Kurk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Importent: If item 27 Is any injury or other treu Deborah Grenier Laurel, Maryland 8383 Sweet Cherry Lane 20723 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 10/4/2004 4 □ Donation 5 □ Other (Specify) Annapolis, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. __ / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Metastatic Carcinoma of Lung Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be executed Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 Diabetes Mellitus 1 Yes 2XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2[XX 1 Yes 2 **X N**o To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 **X**0 1 Inpatient 2 ER/Outpatient XXDOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c, Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No s after death the 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017135 trung September 30, 2004 unemo & 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Lawrence Swink, M.D. 8871 Gorman Road Laurel, Maryland 20723 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** September 29, 2004 RUTH LUCILLE GREGORY 12:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Yrs. 579-36-8476 Director 75 July 13, 1929 Conn Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1.□Yes 2□No Directo MD Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 9278 Cherry Lane #91 20708 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death and of Health and Mental Hygiene. Int: If itam 27 is marked othar than "natural", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Xo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ał Hygiene. s othar than " Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Francis Tatro Hortense Trudel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Gregory spouse 9278 Cherry Lane #91 Laurel, Maryland other 20b. Place of Disposition (Name of Our emeters crematory or other place) 20a. Method of Disposition

↑ ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 5 Department of Important: If any injury or once. ¹ 4 □ Donation 5 □ Other (Specify) Star of the Sea 10/05/2004 Solomans Island, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonia Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XXo Day 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, s been signe should be Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown G I Bleed 24b. Were autopsy findings available prior to completion of cause of death? CVA with aphasia 24a. Was an autopsy performed? page 1 Yes 1 Yes 2X XV0 of Vital Hospitel or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XXP/Outpatient 3 ☐ DOA 1 ☐ Yes 2XXNo Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 1XX atural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To tha Funerel Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D56797 8 30. Name and arress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE AVE LAUREL 13952 TADIKONDA

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

31. Date filed (Month, Day, Year)

House & Specker

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1 2 5 5 5
	Physician /Medical	
	Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Eastpoint Nursing Home Dundalk Baltimore
	Funeral Director	5. Social Security Number 217-24-0992 6. Sex 1 Months 1 M
	Meryland -f ahow	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ifier death with the Meinfer death with the mes 23a or 28a-feiner must be nortified Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1237 Delbert Avenue 21222 USA
020	by Wrs	Specify: White 1 □ Divorced Year or Dates:
Maryland 21215-0020	iene. Than "	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSeWife Own Home
yland	Mentel Hygi Mentel Hygi arked other atic event, I	James E. Connell 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Henning
	nd 2 sho alth end 27 Is m	19a. Informant's Name/Relationship (Type, Print) Calvin S. Connell Brother 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8933 Chesapeake Avenue Apt B208, North Beach, MD.
Baltimore,	it. Peges 1 e rtment of Hei rtant: if Item njury or othe	20a. Method of Disposition 1 Typerial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October Sacred Heart Of Jesus Cemetery 8,2004 Dundalk, Md.
Ball	permit. Per Depertment Important: any injury pnce.	21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do rollenter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of):
x 68760,	entificete be executed fing physicien encies es the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
P.O. Box	The law requires that the death certificate has been signed by the ettending rage base 2 should be deteched for use as Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Drunknow
Division of Vital Records,	The law requires that the ste has been signed by the page 2 should be deteched.	Was an eutopsy performed? 24a. Was an eutopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death?
/ital F	clan: The ertificete l actor, pag Be Col	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
ion of	hysic his c al din	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 41/ Nursing Home 5 Residence 6 Other (Specify)
Divis	Ne Hospital or Attending P no 24 hours after deeth. The Furneral Director: After pletely filled in by the tuneral edical Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State)
	he Hospk in 24 hour he Funer pletely fill edical	
	Within Com	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/3/04
_		38. Name and address of person who completed cause of death (Item 23e) (Type, Print) OUNGED (1000 2 May let 1 Place Disruptions (4) 2/222
	State Registrar	31. Date filed (Month, Day, Year) 22. Registrer's Signature. OCT 0 6 2004 22 2004

		1 - For Stete Registrar		State of Ma	aryland	-	artmen rtificate					Reg. No.		31506
Physic /Med		Decedent's Name (First, Mic Johr	ı M	lilton	Не	eriot	Sr				2. Date of De Month Septembe	Day		
Exam Funera Directo		5. Social Security Number 216-60-9632	Special 6. Sex	14 Hospit	e (In yrs. las	st birthday) Yrs.		alti	More If Under		8. Date of Bir (Month, Da	th ly, Year)	NA 9. Bi	ath rthplace (State or Foreign country) Md
e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. Cour Md. Ann	-	ındel Co.	_	Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show also Exergise In the notified at	Funeral Director	10e. Street and Number 8305 Flint 11. Marital Status 1□ Never Married 2□ M		2. Was Decedent Armed Forces?		1	Was Deced f Yes, spec	2114 dent of Hi cify Cuba	ispanic Ori n, Mexican		ecify Yes or No Rican, etc.)	US	A A Black, Whi	encan Indian,
=	Completed by	3 ☐ Widowed 4 ☐ Divord	ed lent's Educ hest grade	If Yes, Give Year or Dates: ation completed) College (1-4or 5 N/A		16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	il Occupa	durina mos		ing	16b. Kin	nd of Business	lack Modustry Public Wor
tal Hydral	To Be Co	17. Father's Name (First, Midd Phillip	le, Last)		eriot	na	oorer			er's Name Sarah	e (First, Middle			
e, Mary 1 and 2 sho 1 end 2 sho 1 end 27 is ma	İ	19a. Informant's Name/Relation Celesta P. He		e, Print) Wife		1450	о и.	Stat	e Hig	hway	360, C	Grand	750 praire	50#415 Texas
t. Pages riment of rient: If it		20a. Method of Disposition 1 Burial 2 Coremation 4 Donation 5 Other 21. Signature of Funeral Serv	(Specify)		_	ce of Disponetery, crer eenmot		em.	- !	10-4	-04	Bal	timore,	, Mđ.
		23a. Part1. Enter the disease shock, or heart failure. I	or complication	e cause on each lir	ne.		March er the mod				1101 E	E. No	rth Av	
Attending Physicien: The law requires that the death certificate be executed refeath. Attending Physicien: The law requires that the death certificate be executed with the certificate has been signed by the attending physician and sector. After this certificate has been signed by the attending physician and sector. After this certificate has been signed by the attending physician and sector.		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.b.c.d.	Due to (or as Hwm di Due to (or as Alexa Due to (or as	a conseque a conseque	ince of): Zmn ince of): Civu	pts, mvno nu	1 0	raen		NINNS			
P.O. Box 68 nat the death certifics d by the attending pt etached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3	Ectopic pr Other (sp					2	3d. Date of de Month	elivery Day Year
cords, P.O. w requires that the deben signed by the should be detached	þ	Part II. Other significant cond	litions conf	ributing to death b	ut not result	ing in the u	nderlying c	ause give	en in Part I			obacco us		to the cause of death?
of Vital Records, Physicien: The law requires t ribis certificate has been signe	e Completed	25. Was case referred to med	inal			-			00 81		1 ☐ Yes	osy ormed? 22 No	24b. Were a prior to death?	utopsy findings available completion of cause of s 22 No
Division of Vital Rewithin 24 hours after death, within 24 hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident inve	Honding estigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da		R/Outpatier 28b. Time of Injury		8c. Injun Worl	er: ₄□Nu	ırsing Ho	n <i>(Check only o</i> me 5 ☐ Resi 28d. Describe	dence 6		ecify)
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide det	ald not be ermined	28e. Place of Inj building, et	c. (Specify)				,		City or To	wn, State)		lural Route Number,
To the Hospital Within 24 hours To the Funerel I completely filled	Medical	(Check only 2 [1] Medi	cal Examin	er: On the best and manner sta	f examinatio	ledge, deatl on and/or in	vestigation,	, in my o	oinion, dea	id place, ith occurr	and due to the ed at the time,	date and	place, and du	e to the cause(s)
To with	4	29b. Signature and title of cer	h				2		27	49		09	29/c	th, Day, Year)
4		30. Name and address of ers	Cha	rles	Street			use	ف	WE	D D	1230)	
Regis	tate trar	31. Date filed (Month, Day, Ye	oar) 062		ar's Signatu	/k	Schr	()						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner EORGE LHE If Under 24 Hrs. VERL GEORGES ial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Min. Months Days 1 M 2 F Hours 77-20-0820 Director WINIEW Usual Residence of Decedent the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Maryes 2 □ No s marked other then "netural", or items 23e or 28e-1 si sumatic event, the Medical Examiner must be notified None. Washing Ton by Funeral Directo D.C 10g. Citizen of What Country? 10e Street and Number death with 1312 Lee Gate 20012 Road N.W. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ified within 72 hours after de l'Hygiene.

Other then "neturai", or item Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 KNo Specify: Black 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home ما 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be Moriah MUYDOCK Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Gate Rd~ 1312 Carter. Grand Son WAShing Ton, D.C. 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \$\Burial 2 □ Cremation 3 □ Removal from State Jerusalem Bap+ churchen 10/10/04 Blackstone Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. E Haw Kes 21. Signature of Funeral Service Licensee Funeral Home Robert Blackstone, V9 23824 504 EAST STreeT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2000 1 Ves 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital
within 24 hours e
To the Funerel t
completely filled Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) MO 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

December 1 March 1 Mar			1	For State Registrar	State of Maryland	d / Depa		t of H	lealth a	and M	ental Hyg	_	04	9.5	ΠΩ
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Registrar OCT O C 2004		CARA			32. Registrat's Signat	ura	TOVEY,	١١,	DUITH	11016	11012	000			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARIE HOPKINS PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHORELINE CENTREVILLE QUEEN MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days Hours 1 M 2 5F Yrs. MD Director 214.26.6302 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mential Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Itama 23a or 28a-f show Examiner roust be notified at 1 Yes 2 No QUEEN ANNE **Funeral Director** MO GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 SAWMILL LANE 21638 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 KWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERK 12-TH GRADE EXAMINING NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOSEPH REED CARRIE COOK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) MARRIOTISVILL JOHN WILLIAMS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Importent: If It any Injury or o 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State 10.06.04 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN BALTIMORE 21. Signiture of Funeral Serice picensee 22. Name and Address of Facility 405 YOKK KOAD. BAJTO. MD 23a. Par. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirk, or heart failure. List only one cause on each line. 21. Sign ture of Funeral Service Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 O ROWAR DE 51218 MRTERI /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Examiner burial-transit Due to (or as a consequence of): Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELCI 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 🗆 Yes 2 No Be 25. Was case referred to medical examiner? 6 Per (Specify) 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed attending physicien and Division of Vital Records, P.O. Box 68760, this After t death. after death filled in by within 24 hours a To the Funerel C

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

32. Redistrar's Signature

3a) (Type Print) ENTREUMER

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	lealth and Mental Hygiene

			1 State	Maryland / Depa	artment of Heartificate of De			2001.	2 5 10
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	/Medic		Nellie	Gray	Hatch		October	2 200	
	Examin	er	4a. Fecility Name (If not institution, give street and numb	of Baltimore	4b. City, Town, or Loc	timor	Ġ.	4c. County of De	eath
						Under 24 Hrs.			
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	er de	Funeral	11. Marital Status 12. Was Deced Armed Force	es?	Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.
S	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	K ^{j No}	1 ☐ Yes 2 ☐ No S	Specify:		Specify:	
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<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28a-1 show other treumatic event. Its Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				, Zip Code)
	s 1 and 2 of Health item 27		Grace Pulliam-Niece 20a. Method of Disposition	20b. Place of Dispo	Fairlawn	Ave.			21215
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altimore,	tmen tent: jury		* 4 □ Donation 5 □ Other (Specify)		morial Pa		6/04 Ra	ndallst	own, Md
ga	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee	() M	Name and Address of Arch F/H	West			
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			los W				1 ☐ Yes 2 ☐	No 1□Y	as 2 DyNo
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	To the Hospital or Attending Physicien: within 24 hours after deeth. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base one and manner and manner one	sis of examination and/or inv	s occurred at the time, overtigation, in my opinion	date and place, a on, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
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	N		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	DP A.	0 0.1	+: M-0	k,mp2/215
	V		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	DEIDEN	- FIU	C DA I	1180001	KIND 5 1613
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Amend item # 20b c, perint in Black indelible ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a /Medical (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner timore Tar Social Security Number 6. Sex Age (In yrs. last birthday. If Under 1 Birthplace (State or Foreign
 Opuntry) **Funeral** 1**X** M 2□ F -989 2 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle oppartment of Health and Mental Hygiens. In oppartment of Health and Mental Hygiens "retured", or Items 23a or 28a-1 show Importent: It I fam 75 is marked other than "ratural", or Items 23a or 28a-1 show any Injury or other traumatic event, 11 a Medical Exercitor must be multipled at 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apti 307 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be too 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cade) 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Lansdowne, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eac 21. Signature of Funeral Service Licensee Ave. 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Deat **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signed by the attending physicien end d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24a. Was an /24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 📆 🗛 1 Unpatient 2 ER/Outpatient 2 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury . Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours efter death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammea 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT OG 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Year **Physician** September 27, 2004 JOSEPH INZERILLO 2:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Edward W. McCready Memorial Hospital Somerset If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
February 27, 1912 If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Days Months 1⊠M 2□ F Director 071-32-9108 92 New York **Usual Residence of Decedent** parmit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show yi highry or other treumstic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland _ Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 26863 Hamden Drive 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White Saitimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Completed by 3 S Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) New York City 12 Detective Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Lucrezia D'Angelo Onofrio Inzerillo 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26863 Hamden Drive - Salisbury, MD 21801 Joseph J. Inzerillo (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Cemetery 10/5/04 Farmingdale, NY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bradshaw & Sons Funeral Hom
Mary Beth Bradshaw-Pruitt
306 W. Main Street - Crisfi

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bradshaw & Sons Funeral Home <u> 306 W. Main Street - Crisfield, Maryland 21817</u> Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) BLEEDING Examiner Due to (or es e consequence of) Physician/Medical Examiner nding physicien end use as the burlai-trensit Hospital or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 Due to (or es e consequence of) signed by the at id be datached for Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 ☐ Yes 2ÃNo 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To ig Si s after deeth.

i Director: After this of in by the funeral d 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Netural
2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined n 24 hours after decine Funeral Director 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hospl within 24 hou To the Funer completaly fil 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 48098 9/28/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature CCT 0 6 200

bene & Sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registre AMEND ITEM #10e PER PH C836 167669614 9H Death Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** STEVEN JOHNSON 5:09PM 2004 KT. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DAYWALI ALTIMORE AVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In rs. last birthday) **Funeral** 1**⊠**M 2□ F 220-76-3192 **Director** MAR LAND Usual Residence of Decedent *how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-1 shov the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? A DAYWALT AVE, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "neturel; or lie other treumatic event, I'm Medical Excellent 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺No Specify. Specify BLACK Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHNSON WILLIAM ပ DOROTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout) Number, City or Town, State, Zip Code, 7509 STONESTIFROW CT. BALTIMORE MD 21244
pe of Disposition (Name of Date 20c. Location - City of Town, State DOROTHY JOHNSON (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of He
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any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State CEMETERY 10-09-04 LANSDOWNE, MO ` 4 ☐ Donation 5 ☐ Other (Specify) MT, ZION 22. Name and Address of Michity BROWN JR. FUNERAL HOME DIGON, FULTON AVE., BALTO, MD. 21217 21. Signature of Fun ral Septipe Licensee Approximate Interval Between Onset and Death 23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** B 6000 PRESSURE HIGH YEALS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETED MELLINS 16 YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à END STAGE REMAL DISONE 1 Yes 2 No 3 Probably 4 □Unknown Completed IMMUND DEFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? VIRUS autopsy performed? 1 ☐ Yes 2 0 Kg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3

Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier

-m

29c. License number

029296

29d. Date signed (Month, Day, Year) OCNOBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEVLANZO LOWDEN S. CRAIN HIGHWAY, BALTO, MP.

State Registrar 31. Date filed (Month, Day, Year) DCI & 6 2004 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marion 6:42 PM Jones OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center OWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 223-42-6371 Director December 30, 1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, if a Medical Evarainer must be notified at Baltomone 1 Yes 2 No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Parson Avenue USH or Itams 23a 687 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 To No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 la marked other than "na any injury or other traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) 6 th Laborer Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Jones KoseHa Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6877 Parsen Sawyer/mother Avenue Baltimore MD 21207 V -Tuanita 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10/8/04 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem 21. Signature of Fun-ral Service Licensee 22. Name and Address of Facility
Han P-Close Fun enal Sewice, P.A. 709 Tessier St. Baltimore MD 21201-1925 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? MORBID OBESITY 2 No 1 Yes 1 ☐ Yes of Vital 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 24 hours after le Funeral Dira letely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one)

Registrar DHMH 17 Rev 1/2001

within 2 To the I

29b. Signature and title of certified

OCT 0 6 2004

YHTOMIT 31. Date filed (Month, Day, Year) $\sigma\omega$

M.D., 7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOW,

29c. License number

OSLER DRIVE,

D 24034

TOWSON.

29d. Date signed/(Month, Day, Year)

MARYLAND 21204

10

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Old Sattimore PIKESVIlle 7. Age (In yrs. last birthday, Date of Birth (Month, Day, 9. Birthplace (State Country) If Under 1 Year **Funeral** Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show other traumatic event, It's Medical Examiner - ust be notified at 1 Yes 2 No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural; or item any injury or other traumatic event, Ite Madical Examinat 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No by If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or)5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Williams 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 VBurial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Greene Hive a 6+0WN, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart adure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to for as a conséquence of): /Medical Examiner LITENS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a oprisequence of): Examiner igned by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. | 1 ☐ Yes 2 ☑ ₩6 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 💁 1 Yes To the Hospital or Attending Physician: Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) harles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 6 2004 Vizzal al Registrar

UNK 04-321 04-06262 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MAN		- l	For State	State of	Marylar	•	artment of rtificate of				giene	0.01		
athaniel	C. J		Decedent's Name (First, Middle)	a, Last)			rimouto o	Dea		2. Date of Dea	ith		3. Time o	f Death
	Physicia Medic/		NA	THANIEL C.	JOHNS	ON				Month Septemb	Day er 2	8, 20		2 P M
	Examin		4a. Facility Name (If not institution	, give street and numb	oer)		4b. City, Town,	or Locat	tion of Death			County of De		
		Щ	Laurel Regiona. 5. Social Security Number		Ann /In ure	last birthday)	Laurel		nder 24 Hrs.	8. Date of Birth			George's	
	uneral irector		425-04-1998	XX M 2□F	42	Yrs.	Months Day			4/12/19	62 (62)	M	ISSISSIP	PI
			Usual Residence of Decedent		1.0									
arylar	show	2	10a. State 10b. County			ity, Town or L							10d. Inside C	2 No
the M	or 28a-f show e notified at	Director	MD PRINC	E GEORGES		BELTSV	10f. Zip Code				10a. Citiz	en of What		AA
with	23a or ust be	Di	3911 LAKEHOUS	E ROAD, AP	г 13		207				US		,	
death	rms 2	Funerai	11. Marital Status	12 Was Deced	ent Ever in I	J.S. 13.	Was Decedent of	f Hispanio	c Origin? (Spe	ecify Yes or No-	1	4. Race - A	merican Indian,	
36 s after	or Ita	by Fu	1XXVever Married 2☐ Marr	If Yes, Give			1□Yes XXN		ecify:	,			BLACK	
Ind 21215-0036 be filed within 72 hours after death with the Maryland	isa nyyenthan "natural", or itams 23a or 28a-f shov ovant, I're Medical Examinet mast be notified at	ed b	3 Widowed 4 Divorced		es:	16a. Dece	edent's Usual Occ	upation			16b. Kin	d of Busine	ss/Industry	
21.5 Prin 72	Medic	piet	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	4or 5+)	(Give	kind of work don DO NOT use reti	ie during red)		ing		NAVY DEPT OF DEFENSE		
24 We will	er than	Completed	12 4 COMPUTER RESEARCHER										DEFENSE	
Maryland 21215-0036	kad other	To Be	17. Father's Name (First, Middle, ROBERT JOHNSO							e (First, Middle, MARSHA		Sumame)		
Mary d 2 shou	of nealth and Mental In f itam 27 is markad ott r othar treumatic evan		19a. Informant's Name/Relations EMANUEL JOHNSO		D		ing Address (Stre				-		e, Zip Code)	
C 7	tam 2		20a Method of Disposition		20b.		osition (Name of ematory or other p		_	Date			or Town, State	
mo Page	nent of r		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cF CF	IAPEL H	ILL CHUE	RCH	10/9	9/2004	ВС	LTON,	MS	
Baltimore,	Department of Important: If any injury or once.		21. Signature of Funda GREGO	RY FINK #1	101148	- Z	2. Name and Add 426 CRAI						MD 2106	1
	d.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the dea	th. Do not en	nter the mode of d	ying, suc	ch as cardiac	or respiratory ar	rest,		Approxima Interval Be Onset and	ite itween
/N	ysician Nedical aminer	1	Immediate Cause (Final disease or condition resulting in death)	a	Perd as a conse	quence of):	ic he	ct	dis	ease			Onsor and	Dount
A B	##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (c	i da a consa	quance of,								
, axecute	sician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (o	r as a conse	quence of);								
8760,	the the	dicai E		d										
X 61	attending p for use as	/Mec	IF FEMALE:	23c. If yes, outc	ome of pregr	nancy						3d. Date of	dolinos	-1
Records, P.O. Box 68760,	the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live bir	th 2 ☐ Fel intattime of	tal death 3	□Ectopic pregnal □ Other (specify)					Month	Day	Year
S that	igned by be detac	by Pr	Part II. Other significant conditi	ons contributing to dea	ath but not re	sulting in the	underlying cause	given in F	Part I.	23e. Did to	obacco us	se contribute	e to the cause of	death?
ords aquire	been sig should b		obesity					-		1 🗆 Y	/es 2[]No 3	Probably 4	Unknown
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E	cate h	Con									rmed? 2 □ No	1,20	1? (es 2□ No	
of Vita	is certificate ha director, page	Be	25. Was case referred to medica examiner?	Hospital:		Členko i vi	-5.00	Othor		h (Check only o				-
Phys	r this aral dii	To :r	1 XYes 2 No 27. Magner of Death	28a. Date o		ER/Outpatie 28b. Time	SIL 3 DOA	ijury at Vork?		ome 5 Resid			Бресіту)	
inding	ath. r: After e funer	ation	1 Natural 5 Pendi	ng (Montf igation	i, Day Year)	Injury		Vork?	2 🗆 No					
Division of Vital Records,	after des Diractor f in by the	Certification:	3 Suicide 6 Could 4 Homicide deter	nined 288. Place	of Injury - At g, etc. <i>(Spec</i>	home, farm, s	treet, factory, offic	сө		28f. Location (S City or Tow	Street and vn, State)	d Number or	Rural Route Nur	nber,
Division the Hospital or Attanding	within 24 hours after death. To tha Funarel Diractor: After th completely filled in by the funeral	Medical C		ng Physician: To the Examiner: On the ba and mann	sis of examir									(s)
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	vΔ		30. Name and address of person	who completed cause										
. ^	18	0:	31. Date filed (Month Day Year	Ponica - t	gis y ar's Sig	Kwy11	Penn St	treet	t, Balt	timore,	Mary	land	21201	
1	Sta	ate	UCT 6	6 2004	Bener	per	4	- 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

8 (First, Middle, Last)

		•	1 - State Registrar	otato or marylana	•	cate of Death		No. 0 0 4	31517
	Physicia	an.	Decedent's Name (First, Middle, Last, Decedent's Name (First, Middle, Middl	_			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	DEBORAH 1	RENE)	ohns.		OCTOBER	1 2009	
?	Examin	er	4a. Facility Name (If not institution, give	11 - 1	4b.	City, Town, or Location of Dea		4c. County of Dear	ih '
		55	5. Social Security Number 6. Sec	TAN (105/1) x / 7. Age (In yrs. Ias	st birthday) If U	154TIMOL nder 1 Year If Under 24 Hr		9. Birt	thplace (State or Foreign
	Funeral Director			M 200/F 59	Yrs. Mor	ths Days Hours Mir	8. Date of Birth Month, Day, Y	1945 M	4 RylAnd
	yland low		10a. State 10b. County	10c. City	Town or Location				10d. Inside City Limits
	Mar.	tor	md, N/A	15	Altin	noRE			1 Nes 2 No
	or 28	Funeral Director	10e. Street and Number	0 . 1	10	f. Zip Code	100	. Citizen of What Co	ountry?
	23a	ral	5009 HRANKY	net HVENI				USA	1
	er de	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was D	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, The Medical Examinar must be rediffed at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	1 □ Y	es 2 No Specify:		Specify:	BLACK
21215-0036	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's	Usual Occupation	16	6b. Kind of Business	Industry
215	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	of work done during most of wo OT use retired)	T	01	01.14
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and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)	Aulae		A la	attie (First, Middle, Ma	To	at
Maryland	should I and Meni is marked	2	19a. Informant's Name/Relationship (T	Print)	19b. Mailing Add	iress (Street and Number or F	Rural Route Number, C	City or Town, State,	Zip Code)
	1 and 2 Health ar em 27 is ther trau		TERRY TA	AV/OR	701 1	phaston Co	unt BA	Home	1.21205
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition	cor	ce of Disposition	(Name of		c. Location - City or	Town, State
Ē	Pag nent ant: I		1 🖫 urial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		ng MEN	DO RIALPX 10	17/04/	BAHO M	nd, 1
alt	permit. Page Department o Important: If any injury or once.		21. Signatury of Funeral Service Liven	00/	22. Nam	e and Address of Facility	Jones, Ja	2. Fun.	SVC. PA
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т			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not enter the	mode of dying, such as cardi	ac or r esp fratory arres	t,	Approximate Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEP515					UNKNOWN
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ó	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):				
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	e as t		IF FEMALE:	20.16					
Вох	ath catternate of the catterna	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	death 3 Ector	pic pregnancy		23d. Date of del Month	ivery Day Year
0	he de r the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	atn 5 □ Otne	or (specify)			
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Records,	quires in sigr uld be	ed by					1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
00	aw requir s been si 2 should	Completed					24a. Was an	24b. Were au	itopsy findings available
R	Physician: The lav this certificate has ral director, page 2	mo					autopsy performe 1 Yes 2	death? No 1 ☐ Yes	completion of cause of 2□ No
Vital	ian: rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
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o L	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
isio	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M farm street fr	217, 20	28f Location (Street	et and Number or Ru	iral Route Number
Division	Jor A after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	10, 141111, 311001, 16	iciory, cinico	City or Town,		mar riodio riombor,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Phy	vsician: To the best of my know iner: On the basis of examination	ledge, death occu	irred at the time, date and place	ce, and due to the caus	se(s) and manner as	stated.
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	To To con	Σ	29b. Signature and title of certifier	Malu.	70	29c. License number		I. Date signed (Monti	
	h		· verane		00-1/2	01 5050		COURCE 1,	2004
	18		30. Name and address of person who c		23a) (Type, Print)	5601 LOCH	KAVENO	1 ALD 2	1739
	Sta	te	31. Date filed (Month Per Year) C		yo 19	home Val	(INTING		

Registrar

		4	For State Registrar		State of	Marylan	-	rtment <i>tificate</i>			Mental Hy	/giene Reg. No.	004	31518
п	Physicia		Decedent's Name	(First, Middle, Las	st)						2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	al		ee Kuehn							October			5:07 A ™
	Examin	er	4a. Facility Name (If			ber)				Location of Dear	th		County of Dea	
			5. Social Security No	ritan Hosp		. Age (In yrs.	last hirthday)	Baltin If Under 1		If Under 24 Hrs	8 Date of B		altimore	
	Funeral Director		457 82 630	1	□M 2□F	54	Yrs.		Days	Hours Min		ay, Year)	949 Hous	thplace (State or Foreign ountry) Ston, Texas
			Usual Residence of		21			1						
	nylan ihow		10a. State	10b. County Baltimore	City	1	y, Town or Lo Ltimore	cation						10d. Inside City Limits 1X Yes 2 ☐ No
	Ba-f s	cto	Maryland		<u> </u>	La	LLIIDLE	1						
	with th	Director	10e. Street and Num					10f. Zip 0					zen of What C	ountry?
	a 23g	Funeral		hurst Road	12. Was Deced	lent Ever in II	S 13 V	2121		spanic Origin? (Specify Yes or N	USA	14. Race - Ame	erican Indian
	ther d	Fun	11. Marital Status 1 ☐ Never Marrie	ed 2 Married	Armed Ford	es?		t Yes, specif	y Cubar	n, Mexican, Pue	to Rican, etc.)		Black, Whi	
ğ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23a or 28a-f show ent, the Medical Examination must be notified at	by	3 Widowed		If Yes, Give Year or Dat	1		1 ☐ Yes 2	⊠ No	Specify:			Specify: [white
- C	72 ho	Completed	(Spec	15. Decedent's Ed	ducation		16a. Deced	dent's Usual	Occupa done d	ition furing most of we	orkina	16b. Kii	nd of Business	s/Industry
2	ithin ne.	nple	Elementary/Secon		College (1-	4or 5+)	life. I	DO NOT use	retired)			-		
2	led w lygier her th	Co	17. Father's Name ((Cient Middle Leet	4		Social	Worker		19 Matharia Na	me (First, Middl		vate	
and	Ibe fi	Be	Olyn Charl		,					Doris Ke		e, maiuen	Sumame)	
Maryland 21215-0036	should be to and Mental I is marked o	2	19a. Informant's Na		Tyne Print)		19h Mailir	no Address /	(Street a		SSIEL Iural Route Num	ber City o	r Town State	Zip Code)
<u>8</u>	CA 10 - 68			Kuehn (Hus			1				timore, M			,
ē,	s 1 and 1 Heelth Item 27 other to		20a. Method of Disp		<u> </u>		Place of Dispo	sition (Name	e of		Date		cation - City or	r Town, State
altimore,	permit. Pages Depertment of i Important: If It any injury or o			Cremation 3 ☐ 5 ☐ Other (Specif		tate	-	-		er 7 2004		Balt	imore,Mar	ryland
a	mit.		21. Signature of Fu	neral Service Licer	nsee					s of Facility ral Home	Tro	-		-
m	Depermine Depermine Important ir mportant ir more.		Math	01000	m Cho	nack	1 7	401 Bel	air I	Road Balt:	imore,Mar	yland 2	21236	
П			23a. Part1. Enter the shock, or hea	he disease, or com rt failure. List only	plications that ca	used the deal	th. Do not ent	er the mode	of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between
,	Physician		Immediate Cause (Lung	lance	`							Opset and Death
	/Medical Examiner		resulting in death)	(Due to (c	or as a consec	quence of):			-				
	Examine:	_	Sequentially list co	nditions,	ь. Smoki	ng or as a nonsec	wence off:							
	ted nsit	ulue	Cause (Disease or	injury	5.10.10 (, and any							
	al-trai	Examiner	that initiated events resulting in death) I	S 🔳	c. Due to (c	or as a consec	quence of):							1 1
8760,	icate be executed physiclan and s the burial-transit	dical			d									
Θ	tificat ig phy as th	led												
Вох	death certifii e attending p id for use as	an/In	IF FEMALE: 23b. Was deceden		23c. If yes, outo	come of pregn		∃Ectopic pre	gnancy			1	23d. Date of de Month	olivery Day Year
	0 0 2	SICI	in the past 12	No		ant at time of		Other (spe					MOUTH	Day 18a1
0.	The law requires thet the death ate hes been signed by the atter bage 2 should be detached for r	by Physician/Me	9 ☐ Unknown Part II. Other signif		contributing to de	ath hut not rea	culting in the u	inderking ca	UED ANG	an in Part I	23e Dio	I tobacco u	ise contribute t	to the cause of death?
S S	ires the signed d be det		raitii. Other signii	nount conditions	contributing to do	unii Dat iiot io	salang an ano a	moonlying ca	1030 g.ve	or are are a				Probably 4 □Unknown
Ö	w requir been si should	etec									24a. Wt			autopsy findings available
Record	The law	Completed									aut per	opsy formed?	prior to death?	completion of cause of
a		e Co	25. Was case refer	red to medical						26 Place of D	1 ☐ Yes	2 No	1 □ Ye	s 2 No
Vital		o Be	examiner?		Hospital:	noatient 2	ER/Outpatier	nt 3□ DO/	A Othe		Home 5 € Re		6 ∏Other (So	ecifu)
10		-	27. Manner of Deal	th		of Injury h, Day Year)	28b. Time o		Bc. Injury Work		28d. Describ			,
lo	Attending r death. ector: After by the fune	atlo	1 Natural 2 Accident	5 Pending investigation	on	i, bay rour	Injury	м	1 🗆	Yes 2 □ No				
Division	or Atten after deat Director: in by the	ertification:	3 Suicide 4 Homicide	6 Could not I determined	28e. Place	of Injury - At h	nome, farm, st	reet, factory,	office		28f. Location City or T	(Street an own, State	d Number or F	Rural Route Number,
ā	ital or irs afte rai Dir led in l	O									<u> </u>			
	To the Hospital or Atten within 24 hours after deal To the Funeral Director. completely filled in by the	edical	29a. Certifier (Check only	1 Certifying P 2 ☐ Medical Exa		isis of examin	owledge, deat ation and/or in	th occurred a vestigation,	at the tim in my o	ne, date and plac pinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner a I place, and du	as stated. se to the cause(s)
	thin 2 ths mplet	Med	29b. Signature and	The of contifier	and mann	er stated.		29c.	Licens	e number		29d. Dat	te signed (Mor	nth, Day, Year)
	T × O			11/1					0055				0/04/20	
	V		30 Names and add	ress of person who	completed cause	e of death (Ite	m 23a) (Tuno			·			-, 5 1, 20	
	*		Montin	1 Edolm	~ M D				at I	N9F08 Ra	altimore	MD 2	1201	
	St	ate	31. Date filed (Mor	nth Day Year)	32 Bi	edistrer's Sign	ature				A DEIIIOI C	110 6	. ,	
	Regist	rar		051 0 6	2904	Senew	w &		W. W.					
DI		2001					/	M	1321	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Paul Henry Klunk Sept. 27 2004 16:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Hours Yrs. Director 162-09-9246 87 08/05/1917 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits r items 23a or 28e-f show unermust be notified at 1 Yes 2 ☐ No Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Giles Street, Apt. 2 21078 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: 3 / 44-12 / 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 72 hours after ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: The Medical Exam Specify: δ 3 ☐ Widowed 4 ☐ Divorced White natural. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) within 7 Elementary/Secondary (0-12) College (1-4or 5+) 7th Mason Contractor Self-Employed Pages 1 and 2 should be filed v Iment of Health and Mental Hygie tent: If item 27 is marked other t jury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Charles Klunk Catherine Deller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Giles St., Apt 2, Havre de Grace, MD 21078 Annabelle M. Klunk- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State artment or ortent: If * 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns. 09/30/04 Aberdeen, MD Departi Import eny inj 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. Llaure 123 S. Washington, Havre de Grace, MD 21078 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronany Ar ten Disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medicai signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, COPD. 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case reterred to medical examiner? Be the funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 tnpatient 2 ER/Outpatient 3 DOA this ズィッグス 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) ō ä To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9.27.04. wmam_ D 32 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date tiled (Month, Day, Year)
OCT 0 6 2004

ORIGINAL

Methanimo 1106R

32. Registrar's Signature

evolution

cure be Gran mo 21678

Physician	1 - State Registrer			Ce	rtificate of	Death	Reg.	re Legible. ne 2.004	31520
FILVSICIAL	1. Decedent's Name	e (First, Middle, La	ist)			1	2. Date of Death Month	Day Year	3. Time of Death
/Medical		C. KEENE					OCT. 4	2004	1:20P M
Examiner		_	ve street and number)			or Location of Death		4c. County of Dea	
uneral	5. Social Security N	ST CENTER		e (In yrs. last birthday	TOW:		Date of Righ	BALTIMOR 9. Bii	
erai ctor	214~24~97		1 M 2 D E	81 Yrs.	Months Days		(Month, Day, Ye	Ma Ma	thplace (State or Foreign ountry) ryland
	Usual Residence of	f Decedent 10b. County					4/10/192	3	
ad at	10a. State Maryland	Baltimo:	re	10c. City, Town or L	ore Count	t.v			10d. Inside City Limits 1 ☐ Yes 2XXVo
any injury or other traumetic event, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Nur			34131	10f. Zip Code		100	Citizen of What C	
0	300 Inter	national	Circle			1230		USA	
Funeral	11. Marital Status		12, Was Decedent Armed Forces?	Ever in U.S. 13	Was Decedent of	Hispanic Origin? (Spec pan, Mexican, Puerto R	ify Yes or No-	14. Race - Am	
臣	_	ried 2 Married	Y⊠Yes 2□	No	1 ☐ Yes 2 ◯ No		ican, etc.)	Black, Whi	
d by	3√X Widowed		Year or Dates:	AAAA TT					
elete	1	15. Decedent's E cify only highest gr	ade completed)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of working	7 16b	o. Kind of Business	/Industry
Completed	Elementary/Seco	ondary (0-12)	College (1-4or:	5+)		ng/Refrigerati	ion U.	S. Govern	nent
BeC	17. Father's Name	(First, Middle, Last	1)			18. Mother's Name (den Sumame)	,
To B	William C	. Keene,	Sr.			Bessie L.	Cox		
	19a. Informant's Na	lame/Relationship ((Type, Print)	19b. Mai	ing Address (Stree	t and Number or Rural	Route Number, Ci	ity or Town, State.	Zip Code)
	Eileen J.		<u>(Daughter</u>) 154 20b. Place of Disp		Rd. Baltimo		21050 Location - City or	Town State
	,	•	☐Removal from State	cemetery, cre	ematory or other pla	ice)	luna.	2077	
iniury in iniury	21. Signature of Fu			TIGINAUUU	Cemetery			ltimore,	
any ir		12	2-3-			uneral Hom	0	Belair R	
	23a Part1. Enter t	the disease, or con	nolications that cause	d the death. Do not er	nter the mode of dy	ing, such as cardiac or			Approximate Interval Between
an	Immediate Cause disease or condition	(Final			1ton	SALLUV	e		Onset and Death
1	resulting in death)	•	Due to (or as	a consequence of):		. /			00-001-3
ner	Sequentially list co	anditions,	bP	neun	min	- mult.	ple		Loeeks
nine	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying r injury	Due to (on as		Conc		250		llours
Examiner	that initiated events resulting in death) I	S	c. Due to (or as	a consequence gi):	Chric	c /C			7
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ror use as the buria	15.55.44.5								
an/h	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregnanc	·y		23d. Date of de	*
<u> </u>	1 Yes 25	∑ PNo	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)			MOUNT	Day Year
S			contributing to death b	out not resulting in the	underlying cause di	ven in Part I.	23e. Did tobaco	co use contribute to	o the cause of death?
Physician/Medica			<u> </u>		, g g,				robably 4 Unknown
b	, art in other orgin								
þ							24a. Was an	24b. Were a	utopsy findings available
þ							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
e Completed by	25. Was case refer	red to medical				26. Place of Death (24a. Was an autopsy performed	prior to death?	completion of cause of
director, page 2 should be d			Hospital: 1 Inpati	ent 2□ER/Outpatie	int 3□ DOA Ot		24a. Was an autopsy performed 1 Yes 2	t? prior to death? No 1 ☐ Yes	completion of cause of
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completely filled in by the funeral director, page 2 should be d Medical Certification; To Be Completed by	25. Was case referexaminer? 1 Yes 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	th 5 Pending investigation 6 Could not be determined	28a. Date of Inju (Month, Da on be) 28e. Place of In building, el hysicien: To the best miner: On the basis of and manner st	y Year) 28b. Time Injury 28b	of 28c. Injunction of 28c. Injunction of 28c. Injunction of 10c. Injun	her: 4 Nursing Hominy at rk? I) Yes 2 No 28 Ime, date and place, an opinion, death occurred se number	24a. Was an autopsy performed 1 Yes 2 Check only one) 8 5 Residence id. Describe how in City or Town, Side due to the cause of at the time, date 29d.	prior to death? No 1 Yes a 6 Other (Spennjury occurred at and Number or R tate) e(s) and manner and place, and due Date signed (Monni CFU Be C	completion of cause of s 2 No acify) HOSPICE ural Route Number, s stated. to the cause(s) th, Day, Year) 4, 2005 arles Street

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		1 - For State Registrar	State of Maryla		artment of H <i>tificate of L</i>			ene . № A A A A	21521
Physic /Med		Decedent's Name (First, Middle, Last ETHEL BARBARA	KAMBERGE	R			2. Date of Death Month	Day Year 2004	3. Time of Death 4:10 A M
Exam		4a. Facility Name (If not institution, give MARINER HEALTH (LL	4b. City, Town, or FOREST	Location of Death		4c. County of Death HARFORD	1.
Funera Directo		210 40 0010	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Dec. 14	ear) Coun	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		City, Town or Lo				1	0d. Inside City Limits
h with the 3a or 28a	Funeral Director	10e. Street and Number 1122 H. Spalding		DEL ALI	10f. Zip Code 21014	1	10g	. Citizen of What Coun	itry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic event; it a Medical Exercite mether and lined at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036 od within 72 hours aft giene. er than "natural; or if the Medical Exert	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done d OO NOT use retired)	uring most of worki	ing 16	b. Kind of Business/Inc	dustry
Maryland 2 to 2 should be filed the and Mental Hygi 27 is marked other traumatic event, it	To Be Co	8 17. Father's Name (First, Middle, Last) George (UNK)	/asold	HC	memaker		a (First, Middle, Mai auline Mi	,	
and 2 sho ealth and 1 m 27 is me		19a. Informant's Name/Relationship (T) Robert A. Kambero	ger / Son	111	Conestoga	a Road, B	altimore,	ity or Town, State, Zip Maryland	
Baltimore, permit. Pages 1 a Department of Her mportant: If item only injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	GINOVAI NOIN OLLIO	arkwood	sition (Name of natory or other place Cemetery	10-4	-04 B	c. Location - City or To Baltimore,	
Balt permit. Departr Importe eny inji		21. Sign to 6 of Furer 1 price cens 23a. Part 1 cnts, the disease of complete	cations that caused the de		Name and Address McComas F 1317 Coke	esbury Ro	ad, Abing	don, Maryl	and 21009
Physician /Medical		shock, or theart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	mor	in				Interval Between Onset and Death
68760, ficate be executed by physician and street burial-transit up.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usasset I) any that initiated events resulting in death) Last	Due to (or as a cons						
the death certifing y the attending iched for use as	Physician/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of predictions of the second s	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	y Day Year
ecords, r law requires that as been signed b	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the un	derlying cause giver	n in Part I.		co use contribute to the	
r VITAI HECC ysician: The law r is certificate has be director, page 2 sh	Completed						24a. Was an autopsy performed	prior to com death?	sy findings available indicate of No
ng Ph Merth Ineral	ation: To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3□ DOA Other 28c. Injury : Works	4 Aursing Hon		e 6 □Other (Specify, njury occurred)
UVISION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, stre	et, factory, office	2	8f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
the Hosp in 24 hou the Funer	Medical	one)	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, in my opi	nion, death occurre	nd due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
To To To Com	2	29b. Signature and title of certifier	Di		29c. License			Date signed (Month, D	,
1		30. Name and address of person who co	mpleted cause of death (It		Print)				
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig			<i></i>	-		

			1 - For State Registrar	State of Maryla	•	artment of H			giene Neg. N.2 0 0 4	31522
	· · ·		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith Day Year	3. Time of Death
	Physici /Medio		Michael Wi.	llıs Lynch	<u> </u>	· · · · · · · · · · · · · · · · · · ·			ber 29, 20	04 1:45 p M
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death)	4c. County of De	
			2516 Snydersburg 5. Social Security Number 6. Sex		rs. last birthday)	Hämp If Under 1 Year	stead If Under 24 Hrs.	8. Date of Birt		roll
	Funeral Director			M 2DE	67 Yrs.	Months Days	Hours Min.	Oct 31	r, Year) (irthplace (State or Foreign Country) arvland
	D		Usual Residence of Decedent	1 10	0'r T					
	anylar show	5	10a. State 10b. County Marvland Carro		City, Town or Lo	ocation	Hampste	24		10d. Inside City Limits 1 ☐ Yes 2∑ No
	the M	Director	Maryland Carro	LL		10f. Zip Code	nanpste		10g. Citizen of What C	
	3a or		2516 Snydersburg	Road			21074		USA	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland netural; or Items 23a or 28a-f show Jical Examinar munt be molitied at	by Fu	Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	i	1 ☐ Yes 2 ☐ No			Specify:	white
21215-0036	hour tural		3 Widowed 4 Divorced	Year or Dates:	16a, Dece	dent's Usual Occup	pation		16b. Kind of Busines	s/Industry
15	nin 72 In "ne Medic	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of wor	king	County	·
212	od within giene. er than '	Com	Libition (at y/ 3000) (0 12)	College (1-4or 5+) 2	Co	mputer A				cnment
	I 2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. I is marked other than "netural", or flems 23e or 28e-f show the marked other than "netural", or flems and the molified at renmatic event. The Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	a als				ine (First, Middle,	Maiden Sumame)	
₹		ဥ	Willis Keys Ly		106 14-00	- A dalan - (Cton - A				7-0-4-1
Maryland			19a. Informant's Name/Relationship (Type Mary Lynch Simme)						r, City or Town, State, Sing, MD 2]	
	of Health Item 27		20a. Method of Disposition	20	b. Place of Dispo		1	Date	20c. Location - City of	
E	Pages nent of l int: If Its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	Cremati	· I	30/2004	Hampste	ad, MD
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service License	9 M907	23 • 25	2. Name and Addre	ess of Facility	Eline F	uneral Hon	
_	20 E 2 9		Tweel	MILLA	le				tead, MD 2	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	e cause on each tine.		80-	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	CANCER	of	Tensee				1 Yenn
0	Examiner			Due to (or as a con	sequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease of Hiju.) that initiated events							
90,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a con	sequence of):					
8760	physic the b	dicai								
9 x 6	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pre					23d. Date of de	elivery
Box.	death a atter d for u	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		⊒Ectopic pregnanc; □ Other <i>(specify)</i> _	у		Month	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9∐Unknown						
	es tha igned be del	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute	
Records,	w require been si should l	Completed						3.00	25770-17500	robably 4 Unknown
360	elaw has b	mple						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
la		e Co	25. Was case referred to medical				OC Place of Doo		2 X No 1 ☐ Ye	s 2 No
Vital	Physiclen: this certifical	0	evaminer?	lospital:	2 ER/Outpatier	nt 3 DOA Ott			ence 6 □Other (Sp	acify)
J of		n: T	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year			ry at		ow injury occurred	,
Sior	death. ctor: Aft the fur	catic	2 Accident investigation				Yes 2□No			
Division	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	pital ours a erei [29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge deat	h occurred at the ti	me, date and place	and due to the o	ause(s) and manner s	s stated
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examination)	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my	opinion, death occu	rred at the time, o	late and place, and du	e to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifie			29c. Licens	se number	4	29d. Date signed (Mor	th, Day, Year)
•	_		1 4156L	- m		D3	4313		9-30-	CY
	10		30. Name and address of person who co					c 1	stomereter	41 2
	Sta	ate	Jed 5. ILose ~. 31. Date filed (Month, Day, Year)	32. Registrar's Si		e- PUE	# Z1200	s we	JTMINITEN.	Md 2/151
	Sta Regist		OCT 0 6 2004	La part man	B A	Com May "				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day **Physician** October 04 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs.
Hours Min. Saint Agnes
5. Social Security Number Healthcare 6. Sex 8. Date of Birth (Month, Day, Year) JAN, 15, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F 227-56-7709 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if them 27 is marked other than "naturel", or thems 23a and 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1• Yes 2 □ No MARYLAND 10e. Street and Number 3203 MASSACHUSETTS AVENUE 10g. Citizen of What Country? 2 USA by Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZÑNo Specify: Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -ABORER 12 TIGRADE SETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANDON RESVANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MASSACHUSETTS AVE BALTO MD 2

Date 200. Location - City or Town, State 3203 SANDRA MOODY BALTO, MD, 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State FOREST * 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MO. 21. Signature of Funeral & rvice Licensee 22. Name and Address of Facility BROWN JR, FUNERAL HOME SEPH H. DROWN JR, FUNERALYON AVE. BALTO, MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician Myocardial disease or condition resulting in death) intarction /Medical Due to (or as a consequence of): Examiner Brainstem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit -ntracranic that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stephenson completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed

11

DHMH 17 Rev 1/2001

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32. Registrar's Signature

phenson

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	d Mental Hygier	0001 0
	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	/Medi		ANNA GERTRUDE			SEFTEMBER	
7	Examir	ner	4a. Facility Name (If not institution, give Saint Joseph		4b. City, Town, or Location of De	ath JSON	4c. County of Death Baltimore
	Funeral		Social Security Number 6. Se		If Under 1 Year If Under 24 H	rs. 8. Date of Birth	9 Birthplace (State or Foreign
	Director		215-07-3152	M 25√xF 96 Yrs.	Months Days Hours M		1908 Maryland
	yland Now		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar	ctor	Maryland Baltimor	e County	Towson		1 ☐ Yes 2 ☑ No
	vith th	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	eath v	Funerai	509 E. Joppa Ros		21286	(5	USA
5-0036	4 within 72 hours after death with the Maryland jiene. r than "natural", or liems 23a or 28a-1 show the Medical Exercities must be redified at	þ	1 KN Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu I ☐ Yes 2☐ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	acation 16a. Deced	lent's Usual Occupation kind of work done during most of w	yorking 16b.	. Kind of Business/Industry
2121	within iene. • than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)		
d 2	Hyg Hyg ant,	a)	17. Father's Name (First, Middle, Last)	Seam	18. Mother's N	ame (First, Middle, Maid	Clothing fen Sumame)
Maryland	9 to 20 9	To B	Matthew	Mytka			aszak
Jan	2 sho	ľ	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mailin	g Address (Street and Number or	Rural Route Number, City	y or Town, State, Zip Code)
	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic	1 3	Mrs. Patricia Fin	n (Niece) 1019 20b. Place of Dispos	Breezewick Road	, Towson, M	laryland 21236 Location - City or Town, State
MO			1 Burial 2 Cremation 3 F 1 Other (Specify)	Removal from State	natory or other place)		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Servi Licens	31. Stani	. Name and Address of Facility		ltimore, Maryland
_	8958		Martin D. Laws	SON Process of cash line death. Do not enter	Mitchell-Wiedefe	ld Funeral H	Home, Inc.
			Shock, of heart failure. List only of	ications that caused the death. Do not entended to be cause on each line.	er the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical-		Immediate Cause (Final disease or condition resulting in death)	SEPSIS			Onser and Dealin
	Examiner			Due to (or as a consequence of): CORONARY ARTER	Y DISEASE		
	® #	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a consequence or).			
_	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	67.10%		
68760,	cate be executed physicien and the burial-transit	dicai E		out to (or as a consequence or).			
	rtificat ng phy as the	a					
Вох	death certif e attending id for use a	an/N	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery
	that the death certific ed by the attending p detached for use as	Physician/M	1 ☐ Yes 2 W No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		Month Day Year
<u>a</u>	The law requires that the are has been signed by tho page 2 should be detached.	by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	w require been sig should b					1 ☐ Yes	2 No 3 Probably 4 Unknown
ecc	e law r has be je 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
						performed? 1 ☐ Yes 2 X N	death?
Vital	ysiciai is certii directo	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ★ No	lospital: 1 1 Inpatient 2 ER/Outpatient	Other	eath (Check only one)	. 70
J Of	ding Physician: The h. h. After this certificate h. tuneral director, page	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how inju	
Siol	lendir eath. or: Af the fur	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Monal, Say 18al) Injury	M 1 ☐ Yes 2 ☐ No		
Division	of or Attendate death I Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	sicien: To the best of my knowledge, death	occurred at the time, date and place	e, and due to the cause/	s) and manner as stated
	the Ho lin 24 the Fu	Medical	(Check only 2 Medical Exemir	ner: On the basis of examination and/or inve and manner stated.	estigation, in my opinion, death occ	urred at the time, date ar	nd place, and due to the cause(s)
	To Too	2	29b. Signature and title of certifier	mellimo	29c. License number	29d. D	ate signed (Month, Day, Year)
	1/2		20 Name and add to a large with	, ,,,,,	D 41410	ملاه	mer 01 / 2roy.
	9			mpleted cause of death (Item 23a) (Type, P		~1.1 <i>1</i> ~1~1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1	71/1 /18175 - m. 4 m.m. /
	Sta		31. Date filed (Month, Day, Year)	37 Pegistrar's Signartue	OSLER DRIVE TO	DWSON, MAR	RYLAND, 21204
2.	Registr	ar	UG: 0 200	Page 1			

			Please For Unpend Item 2 1- State Registrer	Type or Print in 325,279,2584219	ed/Dene	3838°		ealth/and	Mental Hyg		2001		525
	Physici /Medio		1. Decedent's Name (First, Middle, Las BRIAN MATTH	ens					2. Date of Dea Month OCTOBER	Da 1	, 2004	7:45	of Death
	Examir	er	4a. Facility Name (If not institution, give ST • AGNES HOSPITAL)	street and number)			y, Town, or LTIMO	Location of Deat RE	h	40	. County of Dea	NIA	
	Funeral Director		27 10 0000	7. Age (In yrs.	. last birthday) FT Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day	, Year)	_ C	Quatar)	te or Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTIN		ity, Town or Lo		VILLE	೭					e City Limits
	with the 3a or 28 If the no	II Dire	10e. Street and Number 162 WINTERS	LANE		10f. Z	ip Code	1228	1	0g. Ci	tizen of What C		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show hy injury or other treumetic event, the Medical Examinat is usafter multiled at Once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		14. Race - Am Black, Whi	erican Indian	· · · · · · · · · · · · · · · · · · ·
15-00	"natura	leted	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	16a. Dece	kind of w	ual Occupa vork done o use retired	luring most of wo	rking	16b. K	ind of Business	/Industry	
212	e filed within al Hyglene. I other than "	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	L	AUN	JORY	AID			HOSP	ITAL	
land	ould be fil Mental H arked oth etic even	To Be	17. Father's Narde (First, Middle, Last) JOSEPH A. HAK	2RIS				18. Mother's Nar	me (First, Middle, I				
Maryland 21215-0036	nd 2 should be lith and Mental 27 is marked 27 is reametic ev		19a. Informant's Name/Relationship (1) RETTY SILER	ype, Print)	1	-		Ind Number or Ri	Ural Route Number			Zip Code) 2122	8
ore,	tges 1 and 2 at of Health : If item 27 I or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo	matory or	ame of other place	e)	Date	20c. L	ocation - City or		
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Fure al Service Licen		ARBU		and Addres		08.04 R FUNE				
	20599		23a. Part 1. Enter the disease, or compshock, or in failure. List only	olications that caused the dea	5	151	BALTI	More N.	AT'L PIKE	1 E	ALTO, N	Approxir	221 mate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Narcotic In	toxicat								Between nd Death
ı	Examiner		Sequentially list conditions,	Due to (or as a conse									
,092	te be executed ysician and e burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect of d						_			
.O. Box 68	death certifical e attending phi d for use as th	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 [Ectopic:	pregnancy specify)				23d. Date of de Month	livery Day	Year
<u>α</u>	Se Go	by	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying	cause give	n in Part I.			use contribute t		
Vital Records,	The law ate has b page 2 si	Completed							24a. Was a autops perform	V	death?	completion	
	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	XER/Outpatier	nt 3 🗆 🗆	Othe Othe	r	ath <i>(Check only on</i> Iome 5□ Reside		6 □Other (Spe	ecify)	
on of	Attending Phrdeath. sctor: After the type the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found 10-1-2004	28b. Time of Injury Unknow		28c. Injury Work	at ? 'es 2 \(\tag{\text{No}}\)	28d. Describe ho	w inju	ry occurred		
Division	I To the Hospitel or Attending Plantin 24 hours after death. To the Funerel Director: After the Completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At Inbuilding, etc. (Special Scene	nome, farm, str				28f. Location (St City or Town			nters	Läne
	e Hospil 24 hour e Funer etely fills	edical (29a. Certifier (Check only one) 1 Certifying Ph 2X Medical Exert	ysicien: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, death ation and/or in	n occurre vestigatio	d at the tim on, in my op	e, date and place	and due to the ca	ause(s	and manner a	s stated. to the caus	e(s)
	To the To the To the	Me	29b. Signature and title of certifier	^		2	9c. License				te signed (Mon		r)
	L'ES		30. Name and address of person who	completed cause of death (Ite				O.C.M.E.			BER 2,20		
	11.62	to	31. Date filed (Month, Day, Year)	20B(O, MD) 32. Registrar's Sign	1	111 F			Baltimore	e, N	Maryland	1 2120	1
	Sta Registi		OCT 0 6 200	4 Seneral	B	10	als	/					

State of Maryland / Department of Health and Mental Hygiene

04-0	5344	
John	McCorr	nack
RJD	1-	For State Ragist

	ROD		1 - State Ragistrar		C	ertificate of	Death	R	eg. No.2	Nu	31526
	Physicia	an	Decedent's Name (First, Middle, L	ast)				2. Date of Deat October		OMA	3. Time of Death 2050P.
	/Medic	al.	JOHN McCORMACK 4a. Fecility Name (If not institution, g	in street and symbol		4h City Tour	as Lonation of Death	OCTOBEL			20301 · M
	Examin	er	University Hosp			Baltimo	or Location of Death		4c. Count	ty of Death	
	Funeral			Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Year		8. Date of Birth (Month, Day,	Vons	9. Birthp	lace (State or Foreign
	Director		029.38.7367	1∏M 2□F	55 Yrs.	Months Days	Hours Min.	JAN 21,	1949	GLOU(CESTER, MA
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	Maryl -f sho	tor	MD unk		HAGERSTO	JWN.					1 ☐ Yes 2 ☐ No
	n the	irec	10e. Street and Number		IIAGLKOT	10f. Zip Code		1	0g. Citizen of	What Cour	
	th with	aiD	18601 ROXBURY RD			21746			USA		
	tems	uner	11. Marital Status	12. Was Decedent Armed Forces?		I. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
36	rs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX ☐ Divorced	1 □ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	40	1 ☐ Yes 2 ☐ No	Specify:		Speci	fv:	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23a or 28a-f show or other treumatic event, If a Medical Exertinal retination to Items.	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occu	pation		16b. Kind of E		HITE dustry
215	thin 7 e. an *n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	life	ONOT use retire	during most of work ad)	ing			
2	filed wi Hygien other th		12	1	TECI	HNICIAN	T		CABI		7/1
anc	ntal Hed ot	Be	17. Father's Name (First, Middle, Las	51)			18. Mother's Name			me)	
2	2 should be and Mental Is marked of eumatic ev	_C	unk 19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ilina Address (Stree	TRANCES t and Number or Run	M. SANT		State Zin	Code)
Š	alth a		KATHLEEN M. BRAN	CALEONE	11		R. GLOUCES			,	
Baltimore,	es 1 a of He fitem r othe		20a. Method of Disposition	Table and the State	20b. Place of Dis	position (Name of ematory or other pla			20c. Location	- City or To	wn, State
Ĕ	Pages ment of ent: If it ury or o		1 ☐ Burial ② Cremation ③ 4 ☐ Donation 5 ☐ Other (Spec	(fy)	BAYVIEV	V CREMATOR	RY INC 10.	05.04	ALTIMO	RE. M	(F)
gall	permit. Pages Department of Importent: If i eny injury or one		21. Signalur of Funeral Service Lio	1	/ l	22 Name and Addr	ess of Facility RAL HOME,			8	
	40204		KELLY OKEGORY		31148	26 CRAIN	HWY SW GI	EN BURNT	E, MD	21061	Approximate
ı	Diam'r.		23a. Par 1. Enter the disease, or co shock, or heart raiture. List on Immediate Cause (Final	y one cause on each li	10.	- 0. L.	o ling, such as carolac	- A	200 7	_	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to lor as	a consequence of):	gui	entricu	eoju	eart		
г	Examiner		Coguestially list appditions	, Muc	cardio	I in	arctiv	W			
,	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
1	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):						
Ď,	be exician buria			Due to (or as	a consequence or,						
9/89	certificate be executed Iding physician and Ise as the burial-transit	Medicai		d							
ROX	attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnanc	v		23d. Da	ate of delive	ry
O.	O O D	Physician/	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)	···		Me	onth	Day Year
J.	requires that the de een signed by the a nould be detached	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause ar	van in Part I	23e Did tob	acco use con	tribute to th	e cause of death?
ds,	signe d be d	d by	, and its entire	contributing to countrib	at not resulting in the	anderlying cause gr	von in raiti.	1 □ Ye	~1	3 Proba	
Vital Records,	> 0 0	Completed						24a. Was an	24h		osy findings available
Ä	9 4 9	дшо						autopsy	ned?	prior to con death?	npletion of cause of
ā	sicien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death	-	□ No	Yes	2□ No
01 <	W =	To B	examiner? 1 🔀Yes 2 🗌 No	Hospital: 1 🔀 Inpatie	nt 2 ER/Outpati	ent 3 DOA	her	me 5 Reside		her (Specify)
	ing P		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da)	ry 28b. Time Year) Injury	Wo		28d. Describe ho	w injury occur	rred	
<u>s</u>	or Attending ifter death. Director: After in by the fune	icati	2 Accident investigati 3 Suicide 6 Could not	be 280 Place of Init	Inc. At home form		Yes 2 □ No	206 Lagation /Ctr	mat and Mum	had a d Occasi	10
DIVISION	al or Attending Phy after death. I Director: After thi d in by the funeral of	Certification:	4 ☐ Homicide determine	building, etc	ury - At home, farm, s c. (Specify)	street, ractory, office		28f. Location (Str City or Town,	, State)	oer or murai	Houte Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	alc	29a. Certifier 1 ☐ Certifying F	hysician: To the best	of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the ca	use(s) and m	anner as sta	ated.
	the Hu in 24 the Fu pletel	edical	(Check only 2 Medical Ext	aminer: On the basis of and manner sta	examination and/or	nvestigation, in my	opinion, death occurr	ed at the time, da	te and place,	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and the objectifier	1. 111	(29c. Licen:			d. Date signe		
			WIV!	MYNX	_	0.C.1	YI.E.	(Octobei	L UZ,	2004
	n		30. Name and address of person who	comple cause of d	eath (Item 23a) (Type	111 P	enn Street	, Baltin	nore, M	Maryla	and 21201

State Registrar 31. Date filed (Month Car, Year) 0CT 0 6 2004

32. Registrar's Signature

Sports

			For State	State of Ma	ryland				nd Mental	Hygien	e 2001	· ·	F 0 12
y.	- 2		Registrar 1. Decedent's Name (First, Middle, Last)		Cen	ificate of	Death	2. Date o	Reg. N	o U U	1 3 Tim	ne of Death
**	nysicia		Eign: to	MiTeL	011				Month		ay Yea	r j	OO PM
	Medic xamin		4a. Facility Name (If not institution, give	street and number)	-11		4b. City, Town,	or Location of			c. County of De	04	
y-,		7	Johns Hopkins Ba				Baltim						
	neral ector		5. Social Security Number 6. Se 11	X 7. Age	(In yrs. last E	Yrs.	If Under 1 Year Months Days		Min. (Month	Birth , <i>Day</i> , Year 4 / 191	9. 6	irthplace (Sta Country)	
Dec 71.1			Usual Residence of Decedent						12/0	4/191	O IVI	aryland	a
anylan	7	_	10a. State 10b. County		10c. City, T	own or Loc	ation						e City Limits
the M	offin	Director	MD Harford		Havr	re de	Grace			140.00			Yes 2 No
death with the Maryland	The	Ö	825 Ontario Street				2107	Ω			itizen of What	Country?	
death	edical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S.	13. W			in? (Specify Yes o Puerto Rican, etc.		14. Race - Ar		٦,
OUSO hours after	autu	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No			Tes, specify Cub ☐ Yes 2 X No		Pueno Rican, etc.	,	Specify: 1		
5-UU36 72 hours af	NE IN	ed b	3 ₩ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	1		nt's Usual Occu			165	Y	Vhite	
within 72 ene.	Medic	Completed	(Specify only highest grad			(Give ki	ind of work done NOT use retire	during most o	of working	100.7	Kind of Busines	ss/industry	
D D D	ם	Com	11th	Odliege (1-407 54		Book	keeper			Oil	Compa	any	
and file	e Va	Be	17. Father's Name (First, Middle, Last)						's Name (First, Mic		n Sumame)		
Noul A	matic	၉	Webster L. Hopkin 19a. Informant's Name/Relationship (T)			10h Mailina	Address (Street	· · · · · · · · · · · · · · · · · · ·	e Greenla or Rural Route Nu		- T O	71.0	
Ma nd 2 sl ulth an 27 is r	other traumatic		W. Lamar Hopkins						, Abingd				
or Head		1	20a. Method of Disposition		20b. Place	e of Disposit	tion (Name of tory or other pla	cel	Date		ocation - City o		-
Pages ment of ment of the	ury or		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)						0/01/04	Hav	re de (Grace.	MD
Daltimo	ny in		21. Signature of Funeral Service Licens	ee 6 · .	10	Mit	Name and Addre	nith Facility	uneral Ho on, Havr				
1.45		7	23a. Part1. Enter the disease, or compl	ications that caused the	ne death o	123	the mode of their	shingto	on, Havr	e de	Grace,		
Dhuoi	nion		Immediate Cause (Final	ne cause on each line				ng, such as ca	ardiac or respirator	y arrest,		Onset a	nate Between nd Death
Physi /Med			disease or condition resulting in death)	Due to (or as a		ce of):	a					His	notes
Exam	iner		Sanuantinity list our life on			014	Fai	lure	2			Ye	ast
D _R	sit	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or a			1						
xecut	al-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a			= LU	NE	DISTA	3.2 P		ya	21
le be e		caiE		The	vaci	c 4	pine	00110	27.1			y Re	20.0
Of VILLAI NECOLUS, F.C. BOX 86/60, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and	as th		TEETUNE .						,			1	
ath ce	or use	Physician/Med	255. Was decedent pregnant	3c. If yes, outcome of 1 Live birth 2			ctopic pregnancy	v			23d. Date of d		
the all	bed;	ysici	in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown	4□Pregnant at tii 9□ Unknown	me of death		other (specify)			-	Month	Day	Year
that if	detac	P.	Part II. Other significant conditions cor	ntributing to death but	not resulting	g in the und	erlying cause giv	ren in Part I.	23e. D	id tobacco	use contribute	to the cause	of death?
w requires to been signe	ed blu	۵	Thoracoo	los. v d	0 -		nculo		1	□Yes 2	Ω √N₀ 3□F	Probably 4	□Unknown
aw re	2 sho	piet	Osteopar	2120					24a. W	has an	24b. Were a	autopsy findin	gs available
The I	page	Completed							— au pe 1 □ Ye	utopsy orformed? s 2 2 No	death?		if cause of
VICAL ician: Sertifica	ector,	Be	25. Was case referred to medical examiner?	lo eniteli					f Death (Check on				
Phys.	ral dir	2	1 ☐ Yes ANNO 27. Manner of Death	lo spital: 1 Ampatient 28a. Date of Injury		Outpatient Time of	3 DOA Oth	4 Nursi	ing Home 5 R			ecify)	
ding :	eunj e	ti Ligor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(ear)	Injury	Wor	yai k? Yes 2⊡No	28d. Descrit	e now inju	y occurred		
Atter er dea	by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home,	farm, stree	t, factory, office		28f. Locatio	(Street an	nd Number or F	Rural Route N	u <i>mber,</i>
ital or urs after	in bei									Town, State			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled in by the funeral director, page 2 should be detached for use as it	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination	ner: On the basis of e	xamination	dge, death o and/or inves	ccurred at the tir stigation, in my o	ne, date and p	place, and due to to occurred at the time	he cause(s) ie, date and	and manner a	s stated. e to the cause	e(s)
To the within 2	ощо		29b. Signature and title of certifier	and manner state	a.		29c. Licens				te signed (Mon		
- s -			1 5.11	18	Two		De	243	83				
ĺ	7		30. Name and address of person who co	mpleted cause of dea	th (Item 23a	a) (Type, Pri	nt) 5131	1100	hum Is	Par V	ren e	Ivria	_ 7
V			W. J. Coreena	when	0		13a	Tim	ore or	2/3	-1224	1	
Re	Stat egistra	_	31. Date filed (Month, Day, Year) OCT 0 6 200	32. Registrar	s Signature	19	Some	21	,				

			1 - For Stete Registrar	State of Maryla		artment of I		•	giene	114	31528
	Physic /Medi		1. Decedent's Name (First, Middle, La: Ann E. Miskelly	st)				2. Date of De Month	ath Day	Year Zoo4	3. Time of Death
	Exami		4a. Facility Name (If not institution, given Union Memorial H			4b. City, Town, o	or Location of De		4c. Co	ounty of Death	
	Funeral Director		224-24-1099	ex 7. Age (In y	rs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th ly, Year)	9. Birth	place (State or Foreig ntry) ginia
	death with the Maryland ms 23a or 28a-f show I must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltim		City, Town or Lo						10d. Inside City Limits
	th with the 23a or 28g	ai Director	10e. Street and Number 11204 Pfeffers			10f. Zip Code 21087	_		10g. Citizer	n of What Cou	ntry?
9000	hours after deal tural', or Items ?	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ※No If Yes, Give Year or Dates:			lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 14.	Race - Americ Black, White, pecify:	etc.
1215-(C1 0 U	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give life, l	lent's Usual Occup kind of work done DO NOT use retire	during most of w	orking		of Business/In	dustry
Maryland 21215-0036	ould be filed within 7 Mental Hygiene. arked other than "n atic event, Ita Medi	To Be Co	17. Father's Name (First, Middle, Last) Ernest Gravely		HOM	emaker		ame (First, Middle,		Home mame)	
	nd 2 shi lith and 27 is m r treum		19a. Informant's Name/Relationship (7) Terry L. Miskel 20a. Method of Disposition 1X Burial 2 Cremation 3	ly (son)	1120 D. Place of Dispo	4 Pfeffe	and Number or F	Rural Route Number - Kinjsv Date	ille,		and 21087
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury or othe		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	St	22	an.Luth.Ca . Name and Addre 1750 Rel	ss of Facility ${f E}$.	06/2004 F. Lass	ahn Fi	neral	e, Marylar Home, P.A and 2108
}	Physician /Medical		23a. Part 1. Enter the diverse, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a CONGES	TIVE	er the mode of dyin	ng, such as cardi	ac or respiratory ar		, raryr	Approximate Interval Between Onset and Death
	Examiner	ai Examiner	Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	VE E equence of):	N DOK AK	POITIS			1	month.
.U. Box 68/	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ny Day Year
rds, P	equires that en signed b ould be deta	by	Part II. Other significant conditions co	entributing to death but not re	esulting in the un	derlying cause give	en in Part I.	23e. Did to	_		e cause of death?
		Completed						24a. Was a autops perfor	sy	prior to con death?	csy findings available npletion of cause of
r Vital	Physician: The this certificate hir ral director, page		25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Othe		ath (Check only or		Other (Specify	
DIVISION OF	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Late of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 '		28d. Describe ho			/
5	Dir the		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)			28f. Location (Si City or Town	n, State)		
	Fur Pos	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exam	sicien: To the best of my ki iner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time stigation, in my op	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and ate and plac	manner as sta ce, and due to	ated. the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier Mac O.	mynn	m)	29c. License				ned (Month, E	
	b		MARC MUGMO,	ompleted cluse of death (Ite	em 23a) (Type, F 33 <i>N. (a</i>	lvert 1	7. #50	O BAL	TIMU	RE M	, 2004 D 21218
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 6 201	32. Registrar's Sign	nature		554	,		,	

			1 - For State Registrer	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of			giene	4 31529
	Physici /Medic	al	1. Decedent's Name (First, Middle, L Hubert M 4a. Facility Name (If not institution, gi	clean		4b Ciby Tourn	or Location of Death	2. Date of Dea Month OCTODE	Day Y	ear / 18:52 M
	Examir Funeral	er	Northwest H 5. Social Security Number 6.	OSPITAL Sex 7. AS	ge (In yrs. last birthday	Kande	allstawn ir if Under 24 Hrs.	1. MYS	4c. County of	Death Othore Birthplace (State or Foreign Country)
	Director		244-18-5346 Usual Residence of Decedent 10a. State 10b. County	XXM 2□F	87 Yrs.		S TIOUIS (VIII).	11 20	16	NC
	he Maryla 28e-f shor	Funeral Director	MD N 10e. Street and Number	A	Baltim	ore				10d. Inside City Limits 12 Yes 2 □ No
	with	급		7		10f. Zip Code			10g. Citizen of Wha	,
	ns 23	era	2612 Quantico	AVE	Ever in U.S. 13.		L215 Hispanic Origin? (Si	necify Yes or No-		American Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Exami har must be natified at once.	by	1 ☐ Never Married ※※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 24 If Yes, Give Year or Dates:	No	If Yes, specify Cu 1 ☐ Yes XXNo	Hispanic Origin? (S ban, Mexican, Puert o <i>Specify:</i>	o Rican, etc.)	Specify:	White, etc. Black
21	within 72 he lene. • than "netu the Medical	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)		(Give life.		e during most of wor. red)			on Concrete
d 21	filed v Hygie other 1	ပိ	6th grade 17. Father's Name (First, Middle, Las	na na	Cem	ent Fir			Company Maiden Sumame)	7
Maryland	ould be Mental arked o	To Be	Jerry McLean					Jane Mo		
ary	and Mark	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree	et and Number or Ru			ite, Zip Code)
	1 and 2 Health a sm 27 Is		Ruth McLean-W 20a. Method of Disposition	ife	2612	Quanti	ico Ave,	Baltim	ore, Mo	21215
Baltimore	Pages nent of I nt: # ite		Meurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	20b. Place of Dispresentery, cre		ial Park		20c. Location - Cit '04 Arbu	1400
3alti	permit. Pag Department Importent: any injury conce.		21. Signature of Funeral Service Lice	A Solia	2	2. Name and Addr	ress of Facility	AV-74-33		, , , , , , , , , , , , , , , , , , , ,
ī	10200	0 0	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do not en	300 Wak	oash Ave	Balti or respiratory arre	more, M	Approximate
1	Physician /Medical Examiner		Impediate Cause (Final disease or condition resulting in death)	a. Carel	a consequence of):	ala)	IST A	ecides	nt	Interval Between Onset and Death
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	100	`o ' . '	yes.		
8760,	ate be executed hysician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	u sut	ol al	nag		
9	ifficate g phys as the	edic	3	u.		1 0				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	f delivery Day Year
	w requires that the been signed by should be detact	by	Part II. Other significent conditions	contributing to death b	out not resulting in the u	nderlying cause gi	iven in Part I.			te to the cause of death?
of Vital Records,		Completed						24a. Was an autops perform	y prior	
Vita	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		0.	thor	h Check onl on		
n of	ng Physiter this	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju	ry 28b. Time o	IL SEL DOA	4 Nursing no		ence 6 Other (Sow injury occurred	Specify)
Division	To the Hospitel or Attending Physicien: whith 24 hours alter death. To the Funarel Director: After this certification the funarel director, to the funarel filled in by the funaral director.	Certification:	2 Accident investigate 3 Suicide 6 Could not I 4 Homicide determined	on One Place of Ini	ury - At home, farm, sti	M 1]Yes 2 ☐No	28f. Location (Sti City or Town	reet and Number o	r Rural Route Number,
	Hospitel 4 hours a Funerel E ely filled i		(Check only 2 Medicel Exa	miner: On the basis of	of my knowledge, deat f examination and/or in	n occurred at the ti	ime, date and place,	and due to the ca	ause(s) and manne	of as stated.
	o the lithin 2 o the lo the lo the lo	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licen			9d. Date signed (M	
•	F 3 F 8		Muse B		= and	1) +	T42 1		101410	24
	19		30. Name and address of person who	completed cause of d	leath (tem 23a) (Type,	Print)	COUNT	120 0	as dulla	21133
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	Souks	/	• =	wrung 113	10001, 1.4

Physici				Ce.	arment of Health ,28a-f per me rtificate of Deat	(No.	31531
	an	Decedent's Name (First, Middle, Last				2.	Date of Death Month	Day Ye	3. Time of Dea
/Media		Maurie M. Ma			# 65 T		October		
Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Locatio			4c. County of E	
5		9229 North Point 5. Social Security Number 6. Se		rs. last birthday)	Fort Howai		Date of Birth (Month, Day, Y	Baltin 9.	Birthplace (State or Fo Country)
Funeral Director		219-78-5434	XM 2□F 38	Vec	Months Days Hours		(Month, Day, Y $eb. 10$,		ew York
* * =		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Li
) applied	ō	Maryland Baltim	ore		Colgat	e			1 Tyes 2
penint. Tages I and 2 should be manyant. Inclus and death must no manyant. Inclus and feath and Mental Hygiene Inportant: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I're Medical Examinar must be notified at ance.	Director	10e. Street and Number	320		10f. Zip Code		10g	. Citizen of What	t Country?
23a o	a D	412 Scarsdale Ro	ad		21	.224		U.S.A.	
ems er m	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify can, Puerto Ric	Yes or No- an, etc.)		American Indian, Vhite, etc.
or th	J.F.	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 ☐ No Speci		,	Specify: W	
ural	d by	3 Widowed 4 Divorced	Year or Dates:				10		
B 77	Completed	15. Decedent's Edu (Specify only highest grad	fe completed)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	ost of working	16	b. Kind of Busine	ess/industry
iene. Than	J Wo	Elementary/Secondary (0-12)	College (1-4or 5+)		Carpeter			Custom	Care Carpe
Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)				ther's Name (F	irst, Middle, Ma		1
enta rked ic ev	ToB	Maurie M. Marpl	e. Jr.			larilyn	Bass		
s ma	-	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street and Num			ity or Town, Stat	te, Zip Code)
alth an 27 I		Lisa Marple- Wif	e	9229	North Point	Road P.	O. Box	425 Ft.	Howard MD2
of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I		 b. Place of Dispo cemetery, cre 	osition (Name of matory or other place)	Date	20	c. Location - City	or Town, State
ant: h		4 □ Donation 5 □ Other (Specify)		Balt/Was	h Crematory	10/7/	′2004 I	aurel,	Maryland
Departr Import any inj once.		21. Signature of Funeral Service Licens	:00	2:	2. Name and Address of Fac				
. Š = % %		Jessua T	+×5	6	224 Eastern A	venue I	Baltimor	ce, Mary	land 21224
		23a. Part1. Enter the disease, or comp shock or heart failure. List only o	lication that caused the cone cause on each line.	leath. Do not en	ter the mode of dying, such	as cardiac or re	spiratory arrest	1	Approximate Interval Between Onset and Deat
nysician		Immediate Cause (Final disease or condition	a Alcohol In	toxicat	ion				Oliset and Deat
/Medical xaminer		resulting in death)	Due to (or as a con	sequence of):					
	_	Sequentially list conditions,	b. Due to (or as a con	sequence of):					
nsit .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Classes of Injury)	240 (0/ 43 4 50)	304401100 01).					
ician and burial-transit	xar	Causa (Ulsease or injuly that initiated events	c. Due to (or as a con	sequence of):					
) 5 2		resulting in death) Last							
sicia bur	E E	resulting in death) Last	d						
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anding physicia	cal	IE EEMALE:	d. 23c. If yes, outcome of pre		TE atapia araganan			23d. Date of	delivery
ttending pl	cal	IF FEMALE:	1 Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
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		For State	State of Maryland / I	•		lental Hygie	ene On o	011701
		Registrar		Certificate of	Death		No. UU4	0 0 0
Physici	an	Decedent's Name (First, Middle, Last)	-11-			Date of Death Month	Day Year	3. Time of Death
/Medic			015			October		1235 M
Examin	ner .	4a. Fecility Name (If not institution, give s.	i -	4b. City, Town, or	r Location of Death		4c. County of Death	
		NovakuCEST HOSpite 5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	MA	Baltimo	
Funeral Director			M OTHER	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		lace (State or Foreign
		Usual Residence of Decedent				APRIL 27	ME	WYORK
yland iow		10a. State 10b. County	10c. City, Tow	n or Location			1	0d. Inside City Limits
Man I sh	to	MARWAND N.	A	BALTI	MORE	(11-11		1 Yes 2 No
h the	Director	10e. Street and Number		10f. Zip Code	7707		. Citizen of What Cour	itry?
death with the Maryland ms 23a or 28a-f show rmust be notified at		103 N. F	ULASKI S	T.	2122	3	451	1
ems erms	Funeral	11. Marital Status 1	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	lispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No-	14. Race - America Black, White.	
or It	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2. No If Yes, Give	1 ☐ Yes 2 No	Specify:		Specify: 2	D 0 18
21215-UU30 d within 72 hours after death with the Marylan plene. r than "naturel", or items 23e or 28a-f show the Madical Examinati be rollified at	d by	3 Widowed 4 □ Divorced	Year or Dates:				DL	HCK
nat	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of worki to	ng 16	b. Kind of Business/Ind	dustry
within 72 ene. than "na	E C	Elementary/Secondary (0-12)	College (1-4or 5+)				OTAL HEALT	ALC ADE
ING Z be filed tal Hygic d other event, I		17. Father's Name (First, Middle, Last)	CA	SHIERILATIRE	18. Mother's Name	(First, Middle, Ma		HCARE
	Be c	150	ISLER		RETH	-0	WILLI	
neri neti	은	19a. Informant's Name/Relationship (Typ		. Mailing Address (Street)	and Number or Rura	I Route Number, C		
Mar nd 2 sho with and 27 is m	١.	SHONNETTE POOLE	(DAUGHTER) /C	2-610	45K1 57	- 100		
re, N 1 and Health tem 27		20a. Method of Disposition	20b. Place of	f Disposition (Name of	! D	ate 20	HORE HD 2 Location - City or To	wn, State
0 0 0 = 5		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	ry, crematory or other place	1			
Sattim permit. Pag Department Important: I pny injury o		21. Signature of Funeral Service License	METR		Sty 10-1	1012	PALTIHORE	- Hame
ball permit Depart Import eny in		1 Diotrinh	V. W. Olean	JOSEP	+ H. BRI	JUNIK	FUNERA	L'HOME 40 21217
SAME		23a. Part1. Enter the disease, or complic	ations that caused the death. Do					Approximate
Dhusisian		shock, or heart failure. List only one Immediate Cause (Final	0					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	NEER				
Examiner			Litmahaaai	tic Discon	e (=			
	je	Sequentially list conditions, lary, leading to him solate cause. Enter Underlying	Qualc (or as a consequence				-	
nd cuted	Examiner	that initiated events						
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ortifica ing ph	Medi	IF FEMALE:						
S, F.O. BOX of the seath certification of the detached for use as be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 	3 □Ectopic pregnancy			23d. Date of delive	ry Day Year
the dearly the a	sic	1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5 Other (specify)			WOTE	Day
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Kecords, P. The law requires that the has been signed by age 2 should be detailed.	by	Faith, Other significant conditions con	noung to death out not resulting if	i the underlying cause give	en in Part I.	1 ☐ Yes	1	ably 4 Unknown
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HeCOTAS he law requires e has been sigr age 2 should be	ompleted					24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
	S					performed 1 ☐ Yes 2 ☑		2 1 No
r VITAI Iysicien: T	Be	25. Was case referred to medical examiner?	espital:	Oth	26. Place of Death	(Check only one)		
_ > 00 00	L	1 ☐ Yes 2 XNo	1 Inpatient 2 AER/Ou		4 [] Nursing nor		e 6 □Other (Specify)
on on ding Ph h. After th funeral	lon	1 Natural 5 Pending		Fime of 28c. Injury Work	ς?	28d. Describe how	njury occurred	
ISIO ttend death death stor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	700 Place of Injury. At home to		Yes 2 □ No	196 Location /Ctmo	t and Number or Dure	Davida Aliverha
UNISION or Attending after death. Diractor: After in by the fune	Certification:	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, ractory, office		City or Town, S	t and Number or Rura tate)	Houte Number,
ppitel cours cours serel filled		29a. Certifier 1 Certifying Physi	cien: To the best of my knowledge	death occurred at the tim	ne date and place a	and due to the caus	o(s) and manner as at	
UNISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medicel Examin one)	er: On the basis of examination an and manner stated.	d/or investigation, in my or	pinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
ompl	Me	29b. Signature and title of certifier		29c. License	number -	29d.	Date signed (Month, I	Day, Year)
F > F 0		11/1/1/1	6110	DOOS	5441	1	0/3/04	
,		30. Name and address of person which	pleted cause of death (Item 23a)	(Type, Print)	- 111		-10101	
5		5401 Old Court	1 1	alls town,	ml >	1133		
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4	1111			
Registr		OCT 0 8 2004	herva &	Som Hol				

		1	For State	State of N	Maryland /	•	rtment of H		and Mei		iene	101.	21522
			Registrar 1. Decedent's Name (First, Middle, and American State of the Company o	Last)					2.	Date of Deat	h		3. Time of Death
	Physicia	an		Pak					o	otober and the state of the sta	2, 2	2004	5:52 P M
	/Medic Examin		4a. Facility Name (If not institution, g		nr)		4b. City, Town, or	Location o	of Death		4c. C	ounty of Death	
1	_Aaiiii.		Southern Mar	yland Hosp	ital Ce	nter	Clint				Pı	cince G	eorge
	Funeral Director		5. Social Security Number 6 225–88–5684	.Sex 7.7 1⊠M 2□F	Age (In yrs. last i 65	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,		Cour	place (State or Foreign ntry)
		L	Usual Residence of Decedent								1939		
	rylan thow		VA Fairfa	. 3.5	10c. City, To		cation Station					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Be-f s	cto			rair	Lax					0- 0::	14/h 1 O	
	hours after death with the Maryland lural; or Items 23a or 28e-f show al Eraminat must be collified at	by Funeral Director	10e. Street and Number 9415 Eagle Trac	e			10f. Zip Code 22039			'	-	n of What Cour SA	ntry :
	death	nera	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Specif	y Yes or No-	14	Race - Americ	
36	rs after I', or Ite	by Fu	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced		₹No		Yes 2⊠No	Specify:			S	pecify: KOI	
21215-0036	2 hou	ted	15. Decedent's		16	6a. Deced	lent's Usual Occupa	ation	t of working		16b. Kind	of Business/In	dustry
215	within 7 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	DO NOT use retired)	t of working		Dry	/ Cleane	er
2	ed wil	S		4		Owi	er	10 M-sh-	d-Nama //	First, Middle, I	Maidea C	·	
land	ld be fil ental H ked oth ic even	To Be	17. Father's Name (First, Middle, La Eung Sam Pak	ist)					un Ok		vialueri Si	umame)	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene of the Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28e-f show item 27 is marked other than "natural", or Items It	-	19a. Informant's Name/Relationshi Kang Nyeo Pak-		1		ag Address (Street a						
lore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other 2005.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		ile		sition (Name of natory or other plac lemorialPa	_ '	Oct. Date) _		tion - City or To	
Baltimore,	permit. Pa Departme Importent any injury once.		4 □ Donation 5 □ Other (Special Signature of Furreral Service Li		ralli	22	Name and Address	s of Facilit	y Fair	fax Me		al Fune 22032	ral Home
	40200		23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that causely one cause on each	sed the death. E							22032	Approximate Interval Between
. E	Pnysician		Immediate Cause (Final disease or condition	a End s	hista 4	Dotos	atic cor	hered	DRINE	L			Onset and Death
	/Medical Examiner		resulting in death)		as a conse uen	ce of):							2
		ا <u>ا</u>	Sequentially list conditions,	b. 97\013	Ad (X) b))	salt) en	f person	ani e	_				hous
	uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Maga si	- 0	oblama						hoems .
ć	executed in and rial-transit		resulting in death) Last	Due to (or	as a consequen	ce of):	The same						
8760,	cate be ex physician the buria	dlcal	•	d. pangyt	penia.	chen	o suna py	Adi 65	ed				doys
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-trans	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal de It at time of death	ath 3[Ectopic pregnancy Other (specify)				23	d. Date of deliv Month	ery Day Year
of Vital Records, P.O.	uires that the signed by Id be detac	b	Part II. Other significant condition	s contributing to deat	h but not resultin	ig in the u	nderlying cause giv	en in Part I			bacco use es 2 🗆		he cause of death?
COL	w requ	iete		t ni le u						24a. Was a		24b. Were auto	ppsy findings available
Re	The law	Completed	Posp vet ou	faille-	. Mann					autops perfor	med? 2. Z No	death?	mpletion of cause of
tal		0	25. Was case referred to medical	Laga Place	failman			26. Place	e of Death (Check only or			
f V	Physician: this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☑No	Hospital: 1. Inp	atient 2 ER	/Outpatie	nt 3□ DOA Oth	er: 4□NL				Other (Speci	fy)
0 0	ding Ph h, After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28 Day Year)	b. Time o	Wor	k?		d. Describe h	ow injury	occurred	
Sio	Attending Physician: or death, ector: After this certified by the funeral director, I	catl	2 Accident investigation inves	ation	Martine Address			Yes 2 🗆		f Location /S	troot and	Number or Que	al Route Number,
Division	at or Attend s after death I Director: d in by the	Certification:	4 Homicide determin	200. Flace U	, etc. <i>(Specify)</i>	, tarm, st	reet, factory, office		20	City or Tow	n, State)	I VUITIDET OF THUS	ar noute Number,
	To the Hospital or Attendinin 24 hours after deall To the Funeral Director: completely filled in by the	Medical C	29a, Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the bas and manner	is of examination	dge, deat and/or in	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, an ath occurred	d due to the c at the time, d	ause(s) a late and p	nd manner as s place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	<u>`</u> ``			29c. Licens	e number		2		signed (Month,	Day, Year)
	M.		Vetu w	mallan	27 mg	70		0 (288	14		19-	4/04	
	10		30. Name and address of person v					oi	inten	44.0	i - 1	2673	_
	St	ate	31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signatur	Э	ate 101		[R IVA	Miny	CHA	2017	
	Regist		OCT 0 6 2	104	enter	La	Souls	/					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer	State of Marylan	•	artment rtificate				Re	eg. No.	01,	31533
	Physicia		1. Decedent's Name (First, Middle, Last Escolastica	R.	Pin	nentil				2. Date of Deat Month)9/28/2(Year	3. Time of Death 7:25 P M
	/Medic Examin		4a. Fecility Name (If not institution, give 902 Tuckaway Ter:	street and number) race			Ft.	Wash:	ingto	on		nty of Deat CE Ge	eorge's
	Funeral Director		218-38-1314	7. Age (In yrs. 80)	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 02/10/1	1924	9. Birt Co Phi	hplace (State or Foreign untry) 11ppines
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	_	y, Town or Lo		on						10d. Inside City Limits 1 ☐ YesX X X No
	vith the	Direc	10e. Street and Number 902 Tuckaway	T		10f. Zip C		,		1	0g. Citizen o	of What Co	untry?
	death v	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		2074		gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Ame	rican Indian,
900	ours after rel', or Ite	ğ	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	1 □ Yes ŽÃ No If Yes, Give Year or Dates:		1 🗆 Yes 2		Specify:			Spec	city: F	ilipino
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then *neturel', or items 23a or 28a-f show any injury or other treumatic event. The Medical Experiment intelligible at Once.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) , College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d retired	luring most)	t of workin	ng	16b. Kind of	Business/	·
Maryland 2	uld be filed Aental Hygirked other tic event.	To Be C	17. Father's Name (First, Middle, Last) Miguel Ragadio							(First, Middle, I		ame)	
Mary	12 sho h and h 7 is ma treuma		19a. Informant's Name/Relationship (7) May Sarmiento / Da		1					<i>R</i> oute Number t. Wash:	-		Zip Code) 20744
	of Healt item 2		20a. Method of Disposition	/ 20b. I	Place of Dispo						20c. Locatio		
Baltimore,	artment cortaint if		¥XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Funeral Service License	Ar1	ington	Nat.	Cem	. 10		2004 . Kalas			Virginia
Ba	Deparenti Deparenti Impor any ir		Mark. K.	alas 1	6	160~0z	xon	Hill	Road	Oxon H	[ill, N	Maryl	and 20745
	Physician /Medical		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a pahoreatic	CAN		of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a consect	quence of):								
	xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease to injury that initiated events resulting in death) Last	cDue to (or as a consec									
68760,	eath certificate be executed attending physician and for use as the burial-transit	cal		d									
.O. Box (the death certify the attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	aldeath 3	∃Ectopic pre ∃ Other (spe						Date of dei Month	ivery Day Year
<u>α</u>	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the L	inderlying ca	use give	en in Part I.		23e. Did to			the cause of death?
I Records,	The tar ate has page 2	Completed								24a. Was a autops perform	sy	b. Were au prior to death? 1 \(\sum Yes\)	utopsy findings available completion of cause of 2 \square No
of Vital	icien: certific rector,	o Be (25. Was case referred to medical examiner?	Hospital:	3 CD/O-44i-	aC Do	Othe	200	of Death	(Check only or		Other (Co.	-i4.)
u of		—	1 ☐ Yes 2 SNo 27. Manner of Death 1 SNatural 5 ☐ Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	4 🗆 190		28d. Describe h	ence 6 CC ow injury occ		ciry)
Division	spitel or Attending ours after death. neral Director: After filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, st	m reet, factory,		Yes 2		28f. Location (S. City or Town		mber or Ru	ural Route Number,
1	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce		ysicien: To the best of my kn niner: On the basis of examin and manner stated.									
	To th withir To th comp	Me	29b. Signature and title of certifer	. /				number					h, Dey, Year)
	18		30. Name and address of person who		m 23a) (Tvoe	Print)	D 35	206			Sente	us he	29,2004
	1,		William T. TAN	INER MO 11		ringst.	m f	San d	For	+ WASHI	ing tun	MA	yfmd
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 6 2	32. Registrar's Sign	L A								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State Registrar	State of Mi	arylaric	_	rtificate of		vieritai i iy	Reg. N	2001	31534		
	Physici	n	1. Decedent's Name (First, Middle, La						2. Date of D Month	, D		3. Time of Death		
	/Medic			. PODZII	MEK				10/	02	12004	2.20 AM		
	Examin	er	4a. Facility Name (If not institution, gi		IS COL	201		TCT/M		4	c. County of Dea			
					e (In yrs. la					irth	,	<u> </u>		
	Funeral Director			1□ M 2 K F	77	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D JAN.	17,	1927	thplace (State or Foreign ountry) MARYLAND		
	and	ł	10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits		
21215-0036	Mary -1 sho	ō	MD. N/A BALTIMORE							1X Yes 2 □ No				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If item 27 is marked other then "neturel", or Iteme 23a or 28e-f show any injury or other treumette event, the Medical Estiminal must be indiffed at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of V								itizen of What Co	ountry?			
		αD	141 S. BOULDI	N STREET			21224				U.S.A.			
		iner	11. Marital Status	I Tyes 2 No If Yes, Give Year or Dates: Education rade completed) College (1-4or 5+) HOU		3. 13.	Was Decedent of H	dispanic Origin? (S an, Mexican, Puert	panic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
		by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced				1⊡ Yes 2⊡ X No			Specify: WHITE 16b. Kind of Business/Industry				
5-0		Completed	15. Decedent's E (Specify only highest g			dent's Usual Occup	during most of wor	king	16b.					
21	Aithin Den.	ig m	Elementary/Secondary (0-12)			life.	O NOT use retired)				DOWEGETG			
	Hygier Hygier other tl	ខិ	8 17. Father's Name (First, Middle, Las			HOUSEWIFE		18. Mother's Name (First, Middle,			DOMESTIC			
Maryland	I be fi	To Be	ROBERT DePASC								n Sumame)			
Ĕ	Pages 1 and 2 should nent of Heatth and Men int: If item 27 is marke iry or other treumetic	P	19a. Informant's Name/Relationship			19h Maili	ng Address (Street	ALICE	DENIS		or Town State	Zin Code)		
Ma			HELEN WATSON/		-		CROUSE					21050		
			20a. Method of Disposition	DIII GIII EIK	20b. Pla	ace of Dispe	osition (Name of		Date		ocation - City or			
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			matory`or other place		/4/04	BA	T.TTMOR	E, MARYLAND		
Ħ	nit. F artme orten injur		21. Signature of Euneral Service Lice		7									
B	Depa Impo any ii			No the		7	2 Name and Addre ILLY & 00 S. C	ONKLING	STREE	T.B	ALTO.	ME MD. 21224		
	res that the death certificate be executed We will be attending physicien and included for use as the burial-transit be detached for use as the burial-transit included.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	d the death.						101	Approximate Interval Between		
			Immediate Cause (Final disease or condition		METASTATIC POOLLY DIFFERENT					7A	TED	Onset and Death		
			resulting in death)	Due to (or as					CAN	CE	R			
4			Sequentially list conditions	b										
		ner	t any, leading to immediate cause. Enter Underlying	Due to (or an a consequence of):										
		Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
60,			,	bus to (or as a consequence or).										
68760,		ledical		d										
			IF FEMALE:				□Ectopic pregnancy □ Other (specify)				23d. Date of delivery			
Вох		ciar	23b. Was decedent pregnant in the past 12 months?								Month Day Year			
P.O.		hysi	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Months 1 Pregnant at time of death 5 Other (specify) 1 Pregnant conditions contributing to death but not resulting in the underlying requires in Rart 23a. Did tobaccourse contributing to death but not resulting in the underlying requires in Rart 23a. Did tobaccourse contributing to death 23b. Did tobaccourse contributing to death 25b. Did tobaccourse contributing t											
		γP	A part in other significant conditions continuously to dear out for resulting in the underlying cause given in Part.									the cause of death?		
ğ	= 0 =	edit	1 Yes 2 No 35							2□No 3121Pi	obably 4 Unknown			
ဝင္ပ	e law requ has been je 2 should	Completed	24a. Was an autopsy prior to completion of cause of											
Ä	To the Hospitel or Attending Physicien: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page:	ĕ							perf 1 ☐ Yes	ormed?	death?			
ita		Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)				
<u>></u>		2	1 ☐ Yes 24 No	Hospital: Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursing Home 5 Residence 6 Other (Specify)							cify)			
Ē		on:	27. Manner of Death Natural 5 Pending	ton M			Wor	28d. Describe	8d. Describe how injury occurred					
sio		cat	2 Accident investigati 3 Suicide 6 Could not							/Ctrant	and Number of Di	and Double Aliambas		
Division of Vital Records,		Certification:	4 Homicide determine				reet, tactory, office	actory, office City or Town, S			at and Number or Rural Route Number, State)			
	e Ho: 24 h e Fur	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cone)								to the cause(s)			
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens	se number			ate signed (Mont	* '		
			S. Mana	> MD			D006	0687		/	0/03/	12004		
-	/		30. Name and address of person wh	o completed cause of	death (Item	23а) (Туре								
	*		SONY MA	HOMAS	MO	50	301 Co	CH RA	ven	BLV	0, 140	-21239		
	Sta			32. Regist	rar's Signati	ше								
	Regist	rar	OCT 0 6 2004	Blown.	D. A	A STATE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ter 00 /Medical Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner MORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Numbe **Funeral** 1 M 2 □ F Months Days Director and Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tof Health and Mental Hygiene. If itam 27 is marked other than "nature!", or Items 23a or 28e-f shov or other traumatic event, it is Madical Examitian is ust be mailfied at 1 Yes 2 □ No Director Varyland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cditage (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Department Important: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) -Bahiland 21. Signature of Funeral Service Licensee 22. Name and dress of Facility Joseph 2222 W Funeral Bar 1216 10. 23a. Party. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Dispase of Liping that initiated events resulting in death) Last Due to (or at a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed nding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decad 2 Fetal death 3 Ectopic pregnancy jo in the past 12 Month Day Year 5 Other (specify) P.O. 1 been signed by the should be detached Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification: To Be Completed by 1 Tyes 2 🗆 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 20 25 1 Tes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No 2 ER/Outpatient 3 DOA this Director: After the in by the funeral 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Dire 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of License number 29d. Date signed (Month, Dey, Year) -nn 2004 10-01-30. Name and address of person who completed cause of death (f)em 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 0 6 2004 Registrar

			1 - For State Registrar	State of N	/larylan	-	artment of H tificate of			ental Hy	giene Peg. No.	004	311	36			
	° Physic	22	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	Year		of Death						
	/Medi		Emmett	N			Reynolds			9	30 ^{Day}		22	L5 ™			
	Examir	ier	4a. Facility Name (If not institution	, give street and numbe	r)		4b. City, Town, o				4c. (4c. County of Death					
			J.H.H. 5. Social Security Number	6. Sex 7. A	Acc //a um	last birthday)	Balt If Under 1 Year	imore		8. Date of Bi	+b.	NA O Bin	hplace (State				
	Funeral Director		229-34-3884	1 XM 2□F	75	Yrs.	Months Days	Hours	Min.	(Month, Da	iy, Year)	9. Bill	untry)	_			
21215-0036		Director	Usual Residence of Decedent							4–15-	-29		Va	l•			
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside				
	e Ma		Md.	NA Baltimor					imore					1 Y Yes 2 □ No			
	ith th		10e. Street and Number									en of What Co					
	hours after death with the Maryland turel', or Items 23a or 28e-f show at Examir or must be nutified at		2300 E. Hoffr		A Francis III	0 101	21213					USA					
	ter de Item	Completed by Funeral	11. Marital Status	12. Was Deceder Armed Forces	Forces?		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R			Rican, etc.)	- 1	14. Race - American Indian, Black, White, etc.					
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סר			1 X Burial 2 ☐ Cremation		a c	emetery, cren	ratory or other place Forest V					ngs Mil		1			
Baltimore,	- E # = .		 4 □ Donation 5 □ Other (S_i 21. Signature of Funeral Service 		Gai	-	. Name and Addre										
Ba	Depariment Deparement Important Impo		1 Dlade	pwa	nen	_ د	March F.	H. Ea	st	1101	E. No	ce, Md. orth Av)2			
ords, P.O. Box 68760,	cate be executed /Medical Examiner bhysician and sthe burial-transit	ai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	only one cause on each	is a consequ	uence of): HBP uence of):	what		1	1	rrest,		Approxim Interval B Onset and	etween			
	death certific e attending p id for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	Ectopic pregnancy Other (specify)		23	23d. Date of delivery Month Day Year									
	se gu		Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part i.								obacco use res 2 🗆	the cause of	death? Junknown				
	The law ate has b page 2 sl									24a. Was autor perfo	an osy rmed? 2 No	24b. Were aut prior to c death?	opsy finding ompletion of	s available cause of			
/ita	Attending Physicien: Thir death. ector: Atter this certificate by the funeral director, pag		25. Was case referred to medical examiner?			1			of Death	(Check only c							
of \	ye dis		1 ☐ Yes 2 ☐ No			ER/Outpatient			ne 5 Residence 6 Other (Specify)								
п	After Unerg	ion	27. Mann Death 28a. Date of Injury 28b. Time of Injury at Work?							28d. Describe how injury occurred							
Division	tendi death. tor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be														
$\overline{\leq}$	or At after of Direction by	ırtif	4 Homicide determ	building,	etc. (Specify	me, rarm, stre	eet, ractory, office			City or Tov		Number or Hul	ai Houte Nui	mber,			
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai Ce	29a. Certifier (Check only (Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)														
	To the I within 2 To the I complet	Med	one) 29b. Signature and title of certifier	and manner s	stated.		29c. License	e number			29d. Date	signed (Month	Day, Year)				
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	HXI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65/9 N. Charles St. Suite 411 Balto M 21204														
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0	6 2004 32. Reg	trar's Signat	J.	parti				-						

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2004ar Thomas 11:16A. Ragin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A JOHNS HOPKINS HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 27 219-92-4619 Director 28 1977 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits MD N/A Baltimore XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2423 Garrett Avenue 21218 IISA be filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: by Specify. 3 Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " College (1-4or 5+) N/A Elementary/Secondary (0-12) Northern Pipeline Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ent: If item 27 Is marked off Thomas Ragin Sr. Brenda Lee Anthony 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any Injury or other treu once. Thomas L. Ragin, Sr.-father 3502 Cardenas Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 10/9/2004 King Memorial Park MD Randallstown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST la 1101 E. North Avenue Baltimore, MD wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE GUNERLOT /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ur as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medicai as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? funeral director, page 2 12 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2X EP/Outpatient 3 ☐ DOA ို this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury SUBTECT WAS SHOT 10/2/04 after death. 1 Tes 2 No 10:40 A M 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by 4- Homicide 2200 BLK GARRETT AVE, BATTITOLE STREET 24 hours a 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainle. So stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ O.C.M.E. OCTOBER 3,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Registrar

State

31. Date filed (Month, Day, Year)

ANA

RUBIO, HO
32. Resistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

OCT 0 6 2004

			State of Maryland / Department of Health and Mer			
			- State Registrar AMEND TTEM #4b PER PHY C836 CHO State AMEND TTEM PHY	Reg. N	0001	31538
	Physici	an	1. Decedent's Name (First, Middle, Last) 2.	Date of Death Month D	ay Year	3. Time of Death
	/Media	cal	JERRI JEROME RICHARDSON S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	eptembe	30,2004 c. County of Death	6-AM
	Examir	ier	4a. Facility Name (If not institution, give street and number) STELLA MARIS AT HERCY HOSPICE BOLTINGRE		N	A
	Funeral			Date of Birth (Month, Day, Year	9. Birthp	place (State or Foreign
	Director			AN.05,19	455 NE	WYORK
	deeth with the Maryland ms 23a or 28e-f show r must be notified at	_	10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	the Marylar 28e-f show	Funeral Director	MARYLING A. A. COUNTY GLEN BURNIE			1 ☐Yes 2 No
	23a or 2	Dir	10e. Street and Number	10g. C	itizen of What Cour	ntry?
2	deeth	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Flyes, specify Cuban, Mexican, Puerto Rice	/ Yes or No-	14. Race - Americ Black, White,	
78	s after dee	y Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	11, 010.7	Specify:	
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Sand	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla it of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-1 shot or other treumatic event, the Madical Examination was be notified at	To Be	EARL D. RICHARDSON SR. GENEY,	A (1)	IMBER	/ //
and a	2 shoul and Me is mark eumati	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip	Core)
3,5	of Health of Hea		ROSLYNR, SCOTT (CLOSE FRIEND) 480 MAINVIEW CT. GL 20a. Method of Disposition (Name of Date			.21061
No.	Pages in the part of the part: If its first or other parts or othe		1 ★Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	200.1	Location - City or To	own, State
alti-C	- E E E		*4 □ Donation 5 □ Other (Specify) ARBUTUS CENETERI / 10 - 08 21. Signature of Funeral Service Licensee 22. Name and Address Facility Box	201	ELTIMORE. FUNERA	HARYLAND
Ø W	Depa Impo any id		which N. Williams 2140 N. FULTON	AVE. B		0.21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Cardion youngh, a			Onset and Death
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Division of Vital Records, P.O. Box	Attending Physician: The law requires thet the death certifica redath. r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Physician/Med	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown			
œ.	ss thet gned b	by P	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
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la	i cian : Th certificate rector, pag		25. Was case referred to medical 26. Place of Death C/	1□ Yes 2⊡No		2 □ No
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Div	el or A s after al Dire	Certification;	4 Homicide determined determined building, etc. (Specify)	City or Town, State	e)	rrioate Namber,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and control one) Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated	due to the cause(s	s) and manner as st od place, and due to	ated. the cause(s)
	o the vithin 2 o the comple	Mec	29b. Signature and title of certifier 29c. License number	29d. Da	ate signed (Month, L	Dey, Year)
	F 3 F 0		DH085H	1	0/1/200	4
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 ~ .	
	U	to.	David Rischera 301 ST MULPI Baltima 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ore m	d. 212	_02_
	Sta Registr		DCT 0 6 2004 Sendra & South			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year .4. RILEY eslie 1:18 PM 3004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. enera Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 ☐ M 2 🕱 F 32 Yrs. MD 217-80-0191 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1'V Yes 2 □ No BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21215 U.S.A. 3000 REISTERSTOWN ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) CLERK FOOD SERVICE, 12th grade NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES L. RILEY MCGRAW ERNESTLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MD 21215 3000 REISTERSTOWN 2D. CHARLES L. RILEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10.08.04 KING PARK RANDALLS TOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNCRAL SERVICES 5151 BALTI MORE NAT'L PIKE BALTO 21. Signature of Funeral Service Licenses aus MD 21229 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15719CI resulting in death) Due to (or as a consequence of): ndomy Sequentially list conditions, if any, leading to authorize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 N 2□ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

Physician

/Medical

Examiner

Director

Be

Completed by Physiclan/Medical Examiner

Be

2

Certification:

Medical

29a, Certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, Ita Medical Examilier must be notified at once.

Physician

/Medical

Examiner

the attending physician and thed for use as the burial-transit

should be detached for

signed by

1

State Registrar

31. Date filed (Month, Day, Year) OCT 0 6 2004

29b. Signature and titleyof certifier

aine

32. Registrar's Signature

671881

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death OCTOBER 3, 2004 **Physician** Year **PHYLLIS** ROCKMAN 7:33 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1813 COURTYARD CIRCLE PIKESVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Days | Hours | Min. | DEC. 25, 1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 64 Yrs. Director 218-36-7698 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event. It a Medical Frantisar must be redified at Director 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 COURTYARD CIRCLE 21208 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: WHITE 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KRIEGER SARA SPECTOR IRVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other treum once. DEBORAH GREENBERG / DAUGHTER 1682 BULLOCK CIRCLE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cramation 3 ☐ Removal fram State BALTIMORE HEBREW CEM. 10/5/2004 * 4 □ Donation 5 Ø Other (Specify) REISTERSTOWN, MD 21. Signature of Placeral Service I cen lee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition shock, or heart failure one cause on each line Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (T 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar OCT 0 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year SHIRLEY MAE SCALES 2:07 AM OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE, MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Solution of Birth Months Days Hours Min. Feb. 2, 1950 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 217-54-4272 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ?7 is marked other than "neturel", or Items 23e or 28a-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21225 3001 Seabury Road # F Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after all Hygiene. Black, White, etc. 1 Never Married 27 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Records Hospital permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy, Impurtent: If item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Tellington Sr. Lillian Thelma James Tellington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Tellington (Brother) 912 Third St.NW, Wash. DC. 20001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 0/9/04 Glen Burnie, Md. 22. Name and Address of Facility Tri-State F/S/Inc. 21. Signature of Juneral Service Licensee 25a- Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. inco 912 Third St.NW. Wash. DC.20001 Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC ARRYTHMIA disease or condition resulting in death) THREE PAYS /Medical Due to (or as a consequence of): THREE Examiner METABOLIC ENCEPHALOPATHY 01145 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (un as a consequence oi). Examine TEN inding physician and use as the burial-transit END STAGE RENAL DISEASE YEARS that initiated events resulting in death) Last Due to (or as a consequence of): THIRTY HYPERTENSION Physician/Medical NINE YEARS IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physicien: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records. death. within 24 hours after deat To the Funeral Director: completely filled in by the Medical

29a. Certifier

3 Suicide

4 | Homicide

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier MITMIDON PGY-1 INTERNAL MEDICINE

6 Could not be determined

29c. License number RES 000 29d. Date signed (Month, Day, Year) OCTOBER 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA, BELINDA LU, MD

3001 S. HANOVER ST, BALTIMORE, MD

State Registrar

31. Date filed (Month

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend item 1 1 2 3, per Fint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #6&18 PER FH C836 estimate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** PARROUS Day Year LOVAL 2:20 A M 2004 0 /Medical 02 4a Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HIMORE MediCALCENTOR BALTIMORE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 MM 2 □ F Hours 228-01-6170 Director -87 81 Yrs. VA 10-23-1916 Usual Residence of Decedent the Maryland 10a. State 10b. County or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD BALTIMORE, 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or;
ury or other traumatic avant, the Medical Examinat must be up 10g. Citizen of What Country? 2020 FRATHERBED LANE 21207 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 SYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MILLWORK LABORER 11th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OTIE SPARROW 2 TELLY CASHWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOTTIE M. SPARROW 2020 FEATHERBED LANC BALTO MO 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \(\mathbb{Z}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 10.08.04 OWINGS MILLS, MD 21. Signature of Fune al Service License 22. Name and Address of Facility
VAUGHN C. GREENE, FUNERAL SERVICES
5151 BALTMORE NAT'L PIKE BALTO, MD 21729 Vang Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent 9 of) The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day 5 Other (specify) Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown ate has page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 200 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Lannpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1,2 Natural 5 Pending death. Diractor: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. GREENE STREET BALTOMD 21201 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 6 2004

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9036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, It a Mudical Evarular per notified at	tby Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			If Yes, spe		ispanic Origin? in, Mexican, Pu Specify:	r (Speci uerto Ri	can, etc.)		Black, White,		
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Division of	To the Hospital or Attending Physician: white 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide	6 Could no determin	ed 200. Flac	ce of Injury ding, etc. (· At home, far Specify)	m, stree	et, factory,	, office		2	8f. Location (: City or Tox	Street an wn, State	d Numbe	er or Rural	Route Number,	
_	ospital hours uneral y filled		29a. Certifier	Certifying	Physician: To th	ne best of n	ny knowledge,	death	occurred a	at the time,	date and	d place, a	nd due to the	cause(s)	and ma	nner as sta	ited.	-
	the Ho nin 24 the Fu	Medical	one)	2 Medical E	kaminer: On the l	basis of ex nner stated	amination and	Vor inve	estigation,	in my opin	ion, deat	th occurre	d at the time,	date and	i place, a	ind due to	the cause(s)	
	T with	~	29b. Signature and t	itle of certifier		MS				License n		6-71			te signed	(Month, D	lay, Year)	
•	"X"	1	30. Name and addre	ss of person w	ho completed cau	use of deat	h (Item 23a) (1	Type P	rint)	/ jest	وط	16	0	7	16	1/3		
	10	(1)	Muhami	nad Ju	Eliada	2	h (Item 23a) (1 8/ E · /	Rice	in St	L, R	isim	y Su	11/10	NO	4	219	11	
U	Sta Registr		31. Date filed (Mont	TO 6 2	2004	Registrar's	Signature	4	Los	rela	,							
			-															_

		partment of Health and N e <i>rtificate of Death</i>	Mental Hygiene	004 31545
Physician	1. Decedant's Nama (First, Middla, Last)		2. Data of Death Month Day	3. Tima of Death
/Medical	Annie S. Skeberdis		October 2, 2	2004 4:30 P.M.
Examiner	As Escale At the state of the s	4b. City, Town, or Lo	ocation of Daath 4c. Cou	inty of Deeth
**	230 Glenmore Avenue	Catonsvi	lle Balt	imore
Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthda 1 M 2 M F 75 Yrs.	y) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Yaar) July 2,1929	9. Birthplaca (State or Foraign Country) Maryland
2	Usual Residance of Decedant		,	Jan J Land
oth with the Maryland 23e or 28e-f show wat be notified at real Director	10a. Stata 10b. County 10c. City, Town or	Location		10d. Insida City Limits
with the Ma t or 28a-f e be nothing	Maryland Baltimore Cat	onsville		1 ☐ Yes 2X No
er the port	10e. Street and Number	10f. Zip Code	10g. Citizan	of What Country?
ib wi	230 Glenmore Avenue	21228	U.S	٨
officer deeth virtuene 23e niner must	11. Marital Status 12. Was Dacedant Evar in U,S. 13			Ace - Amarican Indian.
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland th end Mentel Hygiene. 7 le marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Armad Forcas? 1 □ Navar Marriad 2 □ Married 1 □ Yas 2 ☒ No If Yes, Giva Yaar or Datas:	. Was Dacedant of Hispanic Origin? (Spin of Yas, specify Cuban, Mexican, Puarto of Taxon of Yas 2⊠ No Specify:	Rican, atc.) E	Black, Whita, atc.
Sho 2 ho	15. Decedant's Education 16a. Dec	edant's Usual Occupation	16h Kind of	Business/Industry
Ple n n n	(Specify only highast grada complated) (Giv	a kind of work dona during most of worki DO NOT use retired)	ing 100. Killd of	business/industry
Part in the least of the least	Elamantary/Secondary (0-12) Collega (1-4or 5+)	omemaker		. II.
and 2 be filed the Hygin of other event, to	17. Fathar's Nama (First, Middla, Last)		(First, Middla, Maiden Sum	n Home
yland ould be fil Mentel H arked out aftic even To Be	The state of the s			ama)
arylar should be and Mente marked imatic ev	Sylvester Scherba	Mary Kos		
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m 27	Paul Skeberdis (Son) 3000) Jackson Ridge Cou	rt Phoenix, M	Maryland 21131
BAITIMORE, MARYIE permit. Peges 1 end 2 should Department of Heelth end Mer important: If them 27 le marke any injury or other traumatic once.	1 20a Mathod of Disposition 20b Blood of Disc	position (Name of amatory or other place) nity Russian	Data 20c. Location	n - City or Town, Stata
Galting permit. Per Department important any infuny any infuny	21. Signature of Funeral Service Licenses	2. Nama and Addrass of Facility		ore, Maryland
Depa impo	Vis () Vi	tzke Funeral Home	of Catonsvill	e, Inc.
CALLES THE PARTY OF THE PARTY O	23a. Part 1. Entar the disaase, or complications that caused tha death. Do not ar shock, or haart failura. List only one cause on each lina.	30 Edmondson Avenu	e Catonsville	, MD 21228
/Medical Examiner transit	Immediata Causa (Final disease or condition rasulting in death) a. Immediate Causa (Final disease or condition rasulting in death) Due to (or es a conse		la Disea	e 5 years
asth certificate be executed attending physicien and for use es the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conservation of the conservation o			
nat the death cert d by the attendin letached for use	d Part II. Other eignificant conditions contributing to death but not resulting in the u	andarbina source situas in Post I		
es that the de igned by tha a be detached by Physic	Adritis	nounying cousa givan iii Fait I.	1 Yas 2 No	ontribute to the cause of death? 3 □ Probably 4 □ Unknown
The law requires that the death certele has been signed by the attending pege 2 should be detached for use Completed by Physician/N			24a. Was an autopsy parformad?	24b. Ware eutopsy findings availabla prior to complation of causa of daath?
			1 Yas 2 No	1 ☐ Yas 2 ☐ No
2 p 2 m	25. Was cese refarred to madical axaminar?	26. Place of Death	(Check only one)	
Physic this or ral direction of the control of the	1 ☐ Yas 2 ☐ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatian	nt 3□ DOA Othar: 4□ Nursing Hom	a 5☐ Rasidence 6 ☐ Ot	har (Spacify)
neral nerth	27. Menner of Deeth 28a. Date of Injury 28b. Tima o (Month, Day Year) Injury Injury		Bd. Dascribe how injury occu	
Attending or death. actor: After by the fune fill cation	1 ☑Natural 5 ☐ Pending (Month, Öay Year) Injury 2 ☐ Accidant investigation	Work? M 1 ☐ Yas 2 ☐ No		
Hospital or Attending P 24 hours after death. Funeria Director: After tetaly filled in by the funerial dical Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined 28e. Place of Injury - At home, farm, str building, atc. (Specity)	aat, factory, office 25	Bf. Location (Straat and Num City or Town, Stata)	bar or Rural Routa Number,
Hoepi 14 hou Funer Faly fill ICal	29a. Certifier (Check only one) 1	occurred at the time, date and place, an restigation, in my opinion, death occurred	d due to the cause(s) and m t at the time, date and place,	anner as stated. and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date sions	ed (Month, Day, Year)
	Robert bueles non	N7.00		
F	30 Nome and address of assess	D 23 2	octobe	1 4, 2004
		Print DZ5Z	VITE Cate	e 4, 2004 passille 2122
State Registrar	31. Data filad (Month, Day, Yaar) QCT 0 6 2004			

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		State of Maryland / Department of Health and	Mental Hygie	ne
_		Registrar Certificate of Death	Reg.	the state of the s
Phy	sician	1. Decedent's Name (First, Middle, Last)		Day Year 3. Time of Death
	edical	Joseph Edward Serio, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	October	4c. County of Death
Exa	miner	ST AGNES HEALTHEARE BALTIMONE		40. County of Death
Fune	rai	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign
Direc		215-30-2871 123 M 2 F 74 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 11,	1929 Maryland
pu s	400	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Aaryle F sho	a			1 ☐ Yes 2 No
the h 28a-	to d	Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code	100	. Citizen of What Country?
with 38 or		322 Osborne Avenue 21228	109.	U.S.A.
death	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
after after	Ē	Armed Forces? If Yes, specify Cuban, Mexican, Puen 1 ☐ Yes 2 ☑ No If Yes, Siece 1 ☐ Yes 2 ☑ No Specify:	to Hican, etc.)	Black, White, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene Hyfiber then "naturel", or Items 23a or 28a-f show not the Medical Engine or 18 and	Ę	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: White
15-	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	rking 16b	b. Kind of Business/Industry
212 within	l d	Elementary/Secondary (0-12) College (1-4or 5+) Sales		Sporting Goods
Filed of Hyg	B C	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, Maid	
Maryland In a should be file Ith and Mental Hy 27 Is marked oth	ToB	Joseph Serio Rose	Hickey	
and he same		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Number, Ci	ity or Town, State, Zip Code)
and and mark		Lewis Yeager (Brother-In-Law) 2011 Oak Lodge Road		Le, MD 21228
Or of H	5	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State
Baltimore, Jermit. Pages 1 ar Department of Hea Miportants It free Miportants It free		'4 Donation 5 Other (Specify) New Cathedral Cemetery 10	0-5 - 04 Ba	altimore, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 271s marked other than any instured; or Items 23a or 28a-f show any injury or puter fraumitic awant.	once	22. Name and Address of Facility Witzke Funeral Hom 1630 Edmondson Ave	e of Caton	nsville, Inc. ille, Maryland 21228
Priysicii /Medic Examin	al ier	23af Part 1. Enter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	oraco e	Interval Between
68760, trificate be executed g physician and as the burial-transit	edical Exa	that initiated events ' c. Due to (or as a consequence of): d. d.		
P.O. Box 6 that the death certification of by the attending delached for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
ecords, P law requires that as been signed E 2 should be deta	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
The The	Ω.		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital F Physician: Th this certificate	Be	Hospital:	th (Check only one)	
Phys c	.T	1 Inpatient 2 TENOUtpatient 3 DOA 4 Nursing H	ome 5 Residence	6 Other (Specify)
on on ding Ith.	tion	27. Manner of Death Statural Statural Pending 28a. Date of Injury 28b. Time of 28c. Injury at Work?	200. Describe now ii	ijury occurred
Division or Attending after death. Director After	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	t and Number or Rural Route Number,
Div Safte	Certification:	4 Homicide building, etc. (Specify)	City or Town, St	ate)
Division of Division of To the Hospitel or Attanding Phyship 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To t with To 1	Σ	29b. Signature and title of certifie) 29c. License number		Date signed (Month, Day, Year)
		Jaff Haneson MI DOUS 584	19 Oc	tober 3, 2004
/ 0		30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) Scott Bevgen F. Agnes Don tal 900	Cation A	tober 3, 2004 enve Baltimore
,	State istrar	31. Date filed (Month, Day, Year) OCT 0 6 2004 32. Registrar's Signature Apocks	U	12011111010

AMEND TIEM Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3AH more

None of the second o JANING tor Age (In yrs. last birthday, Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 10 M 20 F -18-Yrs nov. 6960 Director 190 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f shoy other traumatic event, the Madical Examiner must be notified at 1 ☑Yes 2 ☐ No Directo MORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 or Itams 23a 61 death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed withIn 72 hours after 1 ☐ Never Married 2 ☐ Married BIACK 2 No Baltimore, Maryland 21215-0036 þ Specify: 3 ₩Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry EAMSALA permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any Injury or other traumatic event. It a Marked Elementary/Secondary (0-12) College (1-4or 5+) ShorEMAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last Be ohnsor ORENCE < 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or #1000 ,21231 IAn 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Andsolvin 4 □ Donation 5 □ Other (Specify) 10/13 12004 100 SICT 21. Sign dure of Funeral Service Licensee uneral ES 23a. Part1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or caspiratory arrest, shock, or heart failure. List only one cause onteach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CONGESTIVE HEMMI FAMURE /Medical Due to (or as a consequence of): Examiner DEDENTIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit be executed BLINDNESS Due to (or as a consequence of): P.O. Box 68760 ULCE125 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ E3.705 Exposure 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed PLACEMENT PACENAKER 24b. Were autopsy findings available prior to completion of cause of death? OF 24a. Was an HSTOR7 has this certificate 2 No 2 No 1 Yes 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred funeral Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation efter death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20056948 PHYSIUAN 7004 Printer come 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMONE 21217 00 DSEPINN STREE T [ANSINDA 20 527 JAMED 32. Regisfrar's Signature 31. Date filed (Month, Day, Year) QCT 0 6 State 2004 south Registrar

CPM 14-06338 Tohn Shivers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			irtment of He tificate of D		lental I	Hygie Reg.	200	16	31548
	Dhusia	je o	Decedent's Name (First, Middle	, Last)					2. Date of	f Death	Day	Year	3. Time of Death
	Physici /Medio		John		ley	,	Shive	rs Jr.			01, 2		22:05 M
7	Examir	ier	4a. Facility Name (If not institution				4b. City, Town, or I				4c. County	of Death	
			Sinai Hos 5. Social Security Number		e (In yrs. last birti	hday		imore If Under 24 Hrs.	O Data of	Dieth		O Diate	(6)
	Funeral Director			1 1 1 1 1 1 1 1 1 1		rs.	Months Days	Hours Min.	8. Date of (Month	, Day, Ye	(G 2	Coun	
			Usual Residence of Decedent		42				09	25	62		MD
	rylan how	_	10a. State 10b. County		10c. City, Town	or Lo	cation					1	Od. Inside City Limits
	e Ma	Funeral Director	MD NA		Balti	mo	re						1 Yes 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g.	Citizen of V	Vhat Coun	try?
	s 23e	rai	2011 Ridgehi	11 Ave			212					S.A	
	ltam	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 Tyes 2 X		13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	Bican, etc.	No-		e - Americ k, White,	
39	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Exameter must be multified at	by F	1 ☐ Never Married XXMarri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	••	1	☐ Yes ¾ДX No	Specify:			Specify	. B1:	ack
21215-0036	2 hou	ted	15. Decedent		16a.	Deced	ent's Usual Occupat	ion		16b	. Kind of Bu		
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	ad wit	Con	12th grade	na		La	andscapi	ng		В	altin	nore	City
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, L				1	8. Mother's Name	(First, Mic	ldle, Maid	den Surnam	Θ)	
Ž	Men	2	John W. Shiv					Delores					
Maryland	12 sh h and 7 Is n traun		19a. Informant's Name/Relationsh				g Address (Street an						
	1 and Healt am 2 ther	,	altina Shiver 20a. Method of Disposition	s-Wile	20b. Place of	LL	Ridgehi		Bal Date		Ore,		21217
ğ	ages nt of t: If it		1X Burial 2 ☐ Cremation		cemetery	, crem	atory or other place)	1				•	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumetic event, the Medical Exameration and injury or other traumetic event, the Medical Exameration and injury or other traumetic event, the Medical Exameration in the Medical Exameration of the Medi		 4 □ Donation 5 □ Other (Sp. 21. Signatur of Funeral Service to 		King		norial P		8/04	R	andal	list	own, Ma
<u> </u>	Departing Department of the policy in the po		Monaea (2. Suinus	<u> </u>	M 4	arch F/H 300 Waba	West sh Ave	Bal	time	ore.	Md	21215
			231. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lin	the death. Do no	ot ente	r the mode of dying,	such as cardiac o	r respirator	y arrest,	1		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	· Guns	hot u	00	and t	o the	Cho	5-	t		Onset and Death
	/Medical- Examiner		resulting in death)	Due to (or as	a consequence of	f):		A. Carrier					
	LAMITHE	L	Sequentially list conditions,	b		e:							
	ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a	a consequence of	1).							
	xecul al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of	f):							
8760,	icate be executed physician and s the burial-transit	alE											
289		edical		0.									
ŏ	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		o.□(41, 50, 50, 50, 50, 50, 50, 50, 50, 50, 50				23d. Date	of deliver	y
m ·	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other <i>(specify)</i>			-	Mon	th I	Day Year
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ec	e taw has b	nple								itopsy	pr	rior to com	sy findings available pletion of cause of
E H		Co								erformed?		eath? Lyes 2	. □ No
Vital	or Attanding Physician: Thitter death. Diractor: Atter this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	6. Place of Death					
ō	Phys r this ral di	. To	1 X Yes 2 □ No 27. Manner of Death	1 Inpatier			JU DOM	4 Nutsing Hon			6 Othe		
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Division of	Attaner death	ertification:	3 Suicide 6 Could no	ot be 28e. Place of Inju	ry - At home, farm				8f. Location	n (Street	and Numbe	r or Rural	Route Number,
5	al or	Cert	4 Homicide	building, etc	. (Specify) solfcottoal	16	ield Fount	6	City or	Town. ta	1 Parvis	stou I	EL BUH LID
	To the Hospital or Attantwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifying (Check only 2 ☑ Medical E	Physician: To the best of	f my knowledge,	death	occurred at the time,	date and place, a	nd due to ti	ne cause	(s) and man	ner as sta	led.
	he Ho in 24 ha Fu plete	Medical	one) 2X Medical E	xaminer: On the basis of and manner sta	examination and/ ted.	Or inve	estigation, in my opin	ion, death occurre	d at the tim	e, date a	nd place, ar	nd due to t	he cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1. 11	\wedge		29c. License n	umber		29d. D	ate signed	(Month, D	ay, Year)
	Α.			dry "	1		0.	.C.M.E.		Oct	ober	02, 2	2004
	5		30. Name and address of person w	no completed cause of de			rint) Penn Stree	ot Ral+	imore	Mar	ard and	2120	11
24	Sta	te	31. Date filed (Month, Day, Year) OCT 0 6 200	- 4 4 4	r's Signature	_	porks	or, Dari	TINTE!	ricil	Утаги)	212(11
	Registr	ar	UCT 0 6 200	14		70	pur or the traffer						

State of Maryland / Department of Health and Mental Hygiene State Registrament ITEM #20b per fb g836 16 Prtificate not Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** 1340 p M Elizabeth Scott-Jackson 30, 2004 September Hattie /Medical 4h City Town or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X F Yrs. 66 Director 216-34-1028 25 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show It e Modical Examiner must be notified at Baltimore NA XXYes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 Funeral 2434 West Belvedere Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIXNo It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by XWidowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Housing Department 9th grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filitiment of Health and Mental H tant: If itam 27 is marked out jury or other traumatic evan 0 Hosea Scott Mary Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6623 Wycombe Way, Parkville, Md Hattie Brice-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ital any injury or ott Q00.00. 10/07/2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 44 Donation 5 Other (Specify) King Memorial Park 10/5/04 Randallstown, Md 21. Si ne of Funeral Service Ligensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician OF TRACHEOVASCULAR a COMPLICATIONS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PULHONARY DISEASE CHRONIC OBSTRUCTIVE WITH Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner TRACHEOTOMY The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burial-1 Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. F ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign be (1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 AUnknown ATMEROSCLEROSIC MRD10 VACULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Diractor: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 30, 2004 luos. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State granama south Registrar OCT 0 6 2004

29b. Signature and title of certifier

29a. Certifier

Director

Funeral

Be Completed by

2

Examine

Physician/Medical

To Be Completed by

Medical Certification:

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel" or items 23e or 28e-f show any injury or other treumatic event, I'm Medical Exprints I must be notified at

Physician

	Plea	se Type or	Print in E	Black In	delible Ink	. Ensure	All Copies	Are Legi	ible.	
For State Registrar	MEND II	State EM #19b	•		artment of l		l Mental Hyg	jiene eg. No. () (A Company	31550
1. Decedent's Nam	e (First, Middle	e, Last) CECILE			SWERNOI		2. Date of Dea Month OCTOBER)4 ^{Year}	3. Time of Death 6:00 P M
ta. Facility Name (/	If not institution	n, give street and n	umber)		4b. City, Town, o	or Location of De	ath	4c. County	of Death	
STELLA						10NIUM				BALTIMORE
5. Social Security N		6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.	• • •	Months Days	If Under 24 H Hours Mi		Year)	9. Birth	place (State or Foreign
213-30-6		, , , , , , , , , , , , , , , , , , ,	9:	3 Yrs.			MAR.4,1	911		" ENGLAN
Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
MD		N/A				BALTIMO	RF			1 ☑ Yes 2 ☐ No
10e. Street and Nu	mber	117 / 1			10f. Zip Code	DALITIO		0g. Citizen of	What Cou	intry?
		GHTS AVEN	IIIF #304		10.1.2.1	21208		USA	·····ac ooa	,
11. Marital Status	INN IILI		cedent Ever in U.	S. 13.	Was Decedent of h		(Specify Yes or No-		e - Ameri	can Indian.
1 Never Marr	ied 2□ Marr	Armed F			If Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ck, White	etc.
3 X Widowed	_	If Yes. G	Sive		1 ☐ Yes 2 🂢 No	Specify:		Specif	y:	WHITE
		t's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of B	usiness/îr	ndustry
(Spec		st grade completed	(1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of w d)	rorking			•
Elementary/5900	oridary (0-12)	2	(1-401 3+)			REALTOR		REAL E	STAT	E
17. Father's Name	(First, Middle,	Last)				18. Mother's N	ame (First, Middle,	Maiden Suman	70)	
JACK				WISEM.	AN	CAROL	INE t	JNKNOWN		
19a. Informant's Na	ame/Relations	hip (Type, Print)		199-199	g Address (Street	and Number or i	Pural Route Number	, City or Town,	State, Zij	o Code)
MICHAEL	PINTZU	K / SON		2317	MELINDA	DRIVE -	OWINGS M	ILLS, M	ID 21	117
20a. Method of Disp				lace of Dispo	osition (Name of matory or other plan	ca)	Date	20c. Location -	City or T	own, State
1 🕰 Burial 2 l 1 4 □ Donation		3 □Removal from pecify)	n State	-	UNO ARLIN		/4/2004	BAL T	TMOR	E, MD
21. Signature of Lu			1.1				OL LEVINS			
Ac	att 1	Vi With	He				ROAD - P			
23a. Part1. Enter ti	he disease, or	complications that	caused the death				ac or respiratory arm		,	Approximate
shock, or hea Immediate Cause		only one cause on	each line.	.007	1					Interval Between Onset and Death
disease or condition resulting in death)	n	a e y	ra sta	ige	deme	nHa				
		Due to	o (or as a consequ	uence of):						
Sequentially list con if any, leading to im	nditions,	b. Due to	o (or as a consequ	ience off.						
ir any, leading to in dausa Entar Unice Cause (Disease or	PER CORRECT	e Due to	O (OI as a consequ	derice ory.						
that initiated events resulting in death) I	3 ′ ′	c. Due to	o (or as a consequ	ience of):						
,			7 (Or as a consequ	1611C9 OI).						
		d								
IF FEMALE:		00. 14			V -				1	
23b. Was decedent in the past 12		1 Live	utcome of pregnal birth 2 Tetal	death 3	Ectopic pregnancy	,		23d. Dat Mo	te of deliv	ery Day Year
1 ☐ Yes 2 €	No	4∐Preg 9∐Unk	gnant at time of de nown	eath 5	Other (specify)					Day Tour
			A			1. 81	00- 5:4			
antil. Other signif	icant conditio	ons contributing to	death but not resu	liting in the u	nderlying cause giv	en in Paπ I.		_		he cause of death?
							1 ∐ Y€	s 2□No	3 🗌 Prot	pably 4 Whiknown
							24a. Was a	n 24b. \	Nere auto	ppsy findings available mpletion of cause of
							autops perform 1 Yes 2	ned?/	death?	2 No
25. Was case refer	red to medical					26. Place of De	eath (Check only on	-	148	4LI HV
examiner? 1 ☐ Yes 2 🛣	No	Hospital:	Inpatient 2 1	ER/Outpaties	nt 3 DOA Oth	or	Home 5 ☐ Reside		er (Snoril	hospica
27. Manner of Deatl	h		of Injury onth, Day Year)	28b. Time of	28c. Injur	y at	28d. Describe ho			I THE
1 Avatural	5 Pendin	9	ntn, Day Year)	Injury	Wor	k?				
2 Academa	mvasm	ation			M 1 🗆	Yes 2 □ No				
2 Accident 3 Suicide 4 Homicide	nvestig 1 Could 1 6 determ		se of Injury - At ho	me, farm. str			28f. Location (St. City or Town	reet and Numh	er or Rum	ul Route Number,

/Medical Examiner within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ahmood 300 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pauline Rita Stewart October 3, 2004 12:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Frankford Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 □ F 214-14-2965 Yrs. Director 89 Feb. 7,1915 Marvland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other then "natural", or Items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 → Yes 2 □ No Director Marvland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or items 23a any lojury or other traumatic event, II a Mantal 5009 Frankford Avenue 21206 U.S Completed by Funeral .Α. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Co. 10 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Stewart 2 Antionette Mazziotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 Walther Avenue Baltimore, Maryland 21214 Joseph Stewart- Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery10/6/2004 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, Maryland 21224 Approximate Interval Between Onset and Death 23a. Paril . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause of each line. Immediate dause (Final **Physician** 5 Dementra Senile 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Davo 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 10.4.04 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulkinory No 4405 Duniel 821 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

				State of Ma	ryland / De	partment of H	Health and N	-	•	·
			1 - For State Registrar			ertificate of	Death		Reg. No.	1 3/552
	Physic	ian	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	Day _ Ye	3. Time of Death
	/Medi		Edwin			Trusty		RACIO		004 4:30 PM
	Exami	ner	4a. Facility Name (If not institution, giv	8 6	pital	0 111	or Location of Death	,	4c. County of E	
			5. Social Security Number 6. S	- 1/4	(In yrs. last birtho		MORE/ If Under 24 Hrs.	8. Date of Birtl	/	<u> </u>
	Funeral Director			XM 2□F 8		Months Days	Hours Min.	8. Date of Birtl (Month, Day 3-5-	Year)	Birthplace (State or Foreign Country) Md.
	g		Usual Residence of Decedent							
	anylar	_	10a. State 10b. County	NT A	10c. City, Town o	rLocation ltimore				10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show croust be couffled at	Funeral Director	Md. 10e. Street and Number	NA	Da.	10f. Zip Code			10g. Citizen of What	
	with with		633 Aisquith Str	eet Ant.	17ĸ	2120	2		USA	Country:
	death me 2;	era	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cub		ecify Yes or No-	14. Race - A	merican Indian,
	6 after or ite	Ŧ	1 Never Married 2 Married	Armed Forces? 1X Yes 2 □ N If Yes, Give		If Yes, specify Cubi		Rican, etc.)		/hite, etc.
	0036 hours after turel', or ite	d by	3 ₩ Widowed 4 Divorced	Year or Dates:						Black
F	15-(n 72 t	Completed	15. Decedent's Education (Specify only highest graduations)	ducation ade completed)	16a. De	ecedent's Usual Occup live kind of work done te. DO NOT use retired	oation during most of work d)	ing	16b. Kind of Busine	ess/industry
2	within 72 ene. then "na	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Laborer	u)		Construct	ion Worker
Z	filed Hygin	Be C	10th grade 17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle,	Maiden Sumame)	
1	rlan uld be Menta rked ric ev	To B	George		Trusty		Cora		Smith	1
Edwin Trush	Maryland 21215-0036 d2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked other then "natural", or treumatic event, the Medical Exam.		19a. Informant's Name/Relationship (**		ailing Address (Street				e, Zip Code)
7	ore, Mass 1 and 2 of Health et ltem 27 is		Elaine Johnson	Niece		326 N. Dal				21213
(47)	Baltimore, Maryland 21215-0036 permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or iteme 23e or 28e-1 show may injury or other treumetic event, the Mudical Examinations to conflict at 2002.		20a. Method of Disposition 1X Burial 2 Cremation 3	Removal from State		sposition (Name of crematory or other place			20c. Location - City	
	timen rtant:		' 4 Donation 5 ☐ Other (Specif		Md. Vet		9-29		Crownsvi	
	Baltimore permil. Pages i Department of F Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licer	11/2/11/12	an	22. Name and Addre	,		imore, Mo North Av	
			23a. Part1. Enter the disease, or com	plications that cause	the death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Pnysician		inock, or heart failure. List only Immediate Cause (Final dise e or condition	Cond cause on each line	θ.					Onset and Death
	/Medical		resulting in death)	aDu to (or as a	consequence of):					
	Examiner		Sequentially list conditions	Bilgter	al Pn	eumoni	ia			
	/ P 15	iner	Sequentially list conditions, if any, leading of innectate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of					
V	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	consequence of);					
	760, te be ex ysician	cai E		·						
	687 tiflicate g phys as the			_ d						
	Box sath cert attending for use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 □Ectopic pregnancy	,		23d. Date of	
	o deat	Physician/Med	in the past 12 months? 1 🗆 Yes 2 🗆 No	4□Pregnant at t		5 Other (specify)	,		Month	Day Year
	Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph age 2 should be detached for use as it	Phy	9 ☐ Unknown Part II. Other significant conditions of		t not coculting in th	a undarking cause gu	on in Dort I	23a Did tol	nacco uso contribute	to the cause of death?
	cords, P.C w requires that the s been signed by t s should be detach	l by	101	FION	t not resulting in th	e underlying cause giv	ren in Part I.			Probably 4 Unknown
	v requ	Completed	HE					24a. Was a		
	Rec	ldmo	<u> </u>					autops	med? / prior to death	
	Vital Fincien: The certificate	e Co	25. Was case referred to medical				26. Place of Death			es 2 No
	of Vita Physicien: this certifica	O B	examiner? 1 ☐ Yes 2 ☐ ¥o	Hospital: 1 patien	nt 2 ER/Outpa	tient 3 DOA Cth	105		ence 6 Other (S	pecify)
	Division of Vital Records, to Attending Physicien: The taw requires that deer death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time	e of 28c. Injur	y at		ow injury occurred	,,
	ision Attendin death. ctor: Af	Certification:	2 Accident investigation	n			Yes 2 □ No			
	or Att fter de frect n by t	rtifi	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injur building, etc.	ry - At home, farm, . (Specify)	street, factory, office		28f. Location (SI City or Town		Rural Route Number,
	pitel o		29a. Certifier 12 Certifying Ph	waisian. To the best of	f my knowledge de		<u> </u>			[i]
	Division of Vital Re To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exer	nysicien: To the best of niner: On the basis of and manner stat	examination and/o	r investigation, in my o	pinion, death occurr	ed at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within Fo the	Me	29b. Signature and title of certifier			29c. Licens	e number		9d. Date signed (Mo	
			> S. Than	D MD		000	60687		Septemb	er 2004
	1 1/1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	pe, Print)	ρ.		Anli	
	341		sony M. Tho	mas 56	ol Loc	n raver	1 Boul	evard,	baltimo	er 2004 re, MD 21239
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	rs Signature	Society		(

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 20:49 2004 OCTURER /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore N/A ohns Ho If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 53 Yrs. Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 ☐ F 214-54-5437 **Director** MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at MD Baltimore N/A 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 153 N. Streeper Street USA 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or iter 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes % No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A NCIA 12th Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tanner Thomas Woolfolk Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deatrice Malone - Devoted Frierd 153 N. Streeper St. Baltimore, MD 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. King Memorial Pk. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/2004 Randallstown MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Ave., Baltimore, MD 21202 Wans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 4 Unknown GASTROINTESTINAL 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 Tyes Division of Vital o the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deal To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 OCTUBER 3, 2004 ress of perso, who completed cause of death (Item 23a) (Type, Print) GARRETT LASAULE TOHNS HOPKINS BAYVIEW MEDICAL WHER 4940 EASTELN AVENUE BALTIMOSE MANYOUR 31. Date filed (Month, Day, Year) 0CT 0 6 2004 State Registrar

			1 - Stata Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H				f
	Physic /Medi		negistrar Decedent's Name (First, Middle, La Virgin	- 1-10-	reise	Thom	~ .	2. Date of De Month		3. Time of Death Year 7 - 58 p M
	Exami		4a. Facility Name (If not instruction, giv	OSPITAL		4b. City, Town, or BALTIM	ORE		4c. County of	of Death
	Funerat Director		5 Social Security Number 6. S 219-20-9033 Usual Residence of Decedent	ex 7. Age	e (In yrs. last birthday, 86 Yrs.	Months Days	Hours M	n. (Month, Oa	th ly, Year) -1917	Birthplece (State or Foreign Country) MD
	e Maryland 3a-f show	ctor	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
121215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If items 23a or 28a-f show or the traumatic event, the Modical Examinar must be notified at or other traumatic event, the Modical Examinar must be notified at	Completed by Funeral Director	10e. Street and Number 1156 CEDARCROFT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12) 12. 17. Father's Name (First, Middle, Last	12. Was Decedent I Amed Forces? 1 Yes 2 No. If Yes, Give Year or Dates: ducation College (1-4or 5	16a. Dece (Give life.	Was Decedent of Hill Yes, specify Cuba 1 □ Yes 2 ▼ No dent's Usual Occupation of Work of the Company of Work One of Cherr's All	ispanic Origin? n, Mexican, Pu Specify: ation furing most of w	erto Rican, etc.) rorking	Specify: 16b. Kind of Bus	- American Indian, , White, etc. BLACK siness/industry SYSTEM
Maryland	2 should be filed wand Mental Hygie is marked other traumatic event, III	To Be	CHARLES H. WEBSTE	R	19b. Maili	ng Address (Street a	MARY	ame (First, Middle, ELLA DAV Rural Route Number	IS	
Baltimore, Ma	Peges 1 and 2 and 2 and 2 and of Health are ont: If item 27 is ary or other traus		KENNETH THOMPSON/ 20a. Method of Disposition 1 Masurial 2 Cremation 3 C 4 Donation 5 Other (Specification)	Removal from State	208. Place of Dispo	KEMBLE RO	DAD BAI	Date 1-9-2004	MARYLAND 20c. Location - C	21218 City or Town, State ORE, MARYLAND
Balt	pernit. Peges Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licer	1. Mi		2. Name and Addres . 701–31 LA			ORTON & 1	SONS F.H.,INC. ARYLAND 21217
8760,	/Medical Examiner	dical Examiner	23a. Parif Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of):	ler the mode of dying	dial	ac or respiratory ai	retion	Approximate Interval Batween Onset and Death (233 Than but April 1997)
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
rds, P	quires that in signed b uld be deta	ρχ	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause give	on in Part I.			oute to the cause of death?
al Records,		Completed						24a. Was autop perior 1 □ Yes	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 24 No
on of Vital	ding Physicien: Th h. After this certificate funeral director, pag	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day)	y 28b. Time o	28c. Injury Work	at Nursing	eath Check on o Home 5 Resid	85	
Division	or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, str . (Specify)			28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitat or Att within 24 hours after d To the Funeral Direct completely filled in by 1	edical	one)	ysicien: To the best o niner: On the basis of and manner stat	examination and/or in	vestigation, in my op	inion, death occ	curred at the time, o	date and place, and	d due to the cause(s)
	o viti	Σ	29b. Signature and title of certifier	Triper	raerri	D 3	0661	t	clober	Month, Day, Year) 5 Th 2004
	()	ta	30. Name and address of person who 560 (LOCK) 31. Date filed (Month, Day, Year)	Laven	r's Signature	Print) Ba	ltinu	ell, t	(d-21	239
	Sta Registr		OCT O 6 2	8	N A	houth a				

			1- State of Maryland / Department of Health and Certificate of Death	Mental Hygiene
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MAMIE TATE	2. Date of Death Month Day Year Year Year Year Year Year Year
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat NORTH HUSOITA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	own battimore
	Funeral Director		1 M 2 F Yrs. Months Days Hours Min.	
Maryland	a-f show lifted at	ctor	10a. State 10b. County 10c. City, Town or Location Randoustown	10d. Inside City Limits 1 ☐ Yes 2 No
ath with th	23a or 28 ust be no	Funeral Director	106. Street and Number 3812 Brentfold Road 21133	10g. Citizen of What Country?
5-0036 72 hours after death with the Maryland	t, or items	by Fune	11. Marital Status 12. Was Decedent Effer in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (S If Yes, specify Cdban, Mexican, Puerl Yes, Give 1 Yes, Give 1 Yes 2 M No Specify:	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: QIDNV
215-0036	n "natural Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
ind 2121	al Hygiene d other tha vent, tre	d)	12th GRADE Supervisor	Wisiting Nurses ASSOC.
Maryland d 2 should be file	and Ment is marked raumatic e	ToB	NOMON MCGEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num. or Pil.	Ura Route Number, City or Town, State, Zip Code)
Baltimore, Ma	Health a em 27 is ther tra		20a. Method of Disposition 1 Durid 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)	Date 20c. Location City or Town, State 2-CH BOULINGER MIN
Balti permit.	Departn imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility (N. 8728 Lubelety Road	ughn C Greene fundad Service Kandalletown, MD 21133
	nysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	c or respiratory arrest, Approximate Interval Between Onset and Death
	Medical xaminer		resulting in death) Due to (or as a consequence of): Sequentially list conditions b.	
8760, ate be executed	ohysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ecords, P.O. Box 68760, law requires that the death certificate be executed	igned by the attending phy be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 State of the pregnant at time of death 5 Other (specify) 1 State of the pregnancy 1 State of the p	23d. Date of delivery Month Day Year
rds, P	n signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
C 9	ite has been si bage 2 should	Completed		24a. Was an autopsy performed? 1 Yes 2 More autopsy findings available prior to completion of cause of death?
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on of	h. After this funeral dir	tlon: To	1	dome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
Division al or Attending	hours after death. uneral Director: A ly filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ne Hospita	within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	o, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)
Tota	To to	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year) Olo (L. 5, 2007)
•	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	· ·
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 0 6 2004 32. Registrar's Signature Sparks	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Barnes Taylor 09/30/2004 3:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 122 N. Huron Drive Prince George's Forest Heights 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09 (12) 1940 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 XXX 2 □ F 577-54-5509 Washington, DC Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at Maryland Prince George's Forest Heights 1 Yes XXNo Directo 10e. Street and Number 122 North 10f. Zip Code 10g. Citizen of What Country? Huron Drive 20745 USA "naturel", or items 23a permit. Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a any hijury or other treumatic event, Ira Madical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾ Alo Specify: White <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Utilities Systems Repair Operator Federal Gov't 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Henry Taylor Mary Charlotte Hanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Mary Taylor / Wife 122 North Huron Drive Forest Heights, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place). Barnabas Church 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/04/2004 Temple Hills, MD 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility P. Kalas Funeral Home PA 21. Signature of Fundial Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

ADEND CARCINOMA OF LUNG disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 2 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the darrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: To the Hospitei or Attending I within 24 hours after death. To the Funerel Director: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

A WD 8926 WOOD YARD ROAD #201 CLINTON 31. Date filed (Month 32. Registrar's Signature State Registrar

		1 - For State Registrar		-	partment of F Certificate of		R	eg. No.	31557
Dhysiai		1. Decedent's Name (First, Middle,	Last)				2. Date of Deal Month	Day Year	3. Time of Death
Physici: Medic		Margaret	Α.		Thiess	3	October	4, 2004	3:30 P
Examin		4a. Facility Name (If not institution,	give street and number,)	4b. City, Town, o	r Location of Deatl	h	4c. County of Death	
	ψ. 3	Genesis Eldercar	e - Heritag	ge Center	Dundall	ζ.		Baltimor	e
uneral irector		5. Social Security Number 217–07–4265 Usual Residence of Decedent	5. Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. last birtho 86 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 4	, 1918 9. Birth Cou MD	place (State or Fore ntry)
M II		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Lim
Important: If itam 27 is marked other than "natural", or Itams 23s or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	Funeral Director	MD. Balti	more	Dur	ndalk		T-,	0g. Citizen of What Cou	1 □ Yes 2 %]!
Sc or	l Dir	6810 Roberts Ave	nue		2122	22		USA	nuyr
ns 2	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	can Indian,
ritar	Fur	1 ☐ Never Married 2 ☐ Marrie	Armed Forces' d 1 ☐ Yes 2 If Yes, Give	? No			o Rican, etc.)	Black, White,	
o'le	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo	Specify:		Specify: Whi	te
eatura	Completed	15. Decedent's	Education	16a. De	ecedent's Usual Occup	ation		16b. Kind of Business/Ir	ndustry
u o	plet	(Specify only highest	grade completed)	(G	live kind of work done to. DO NOT use retire	during most of wor d)	rking		
than	E C	Elementary/Secondary (0-12)	College (1-4or	5+)	sewife			Own Hom	e
other than ent, Ir e M		9 years 17. Father's Name (First, Middle, La	ast)			18. Mother's Nan	ne (First, Middle, I		
arkad o	Be	James Moore	-5.7				Gerlock		
nark	2								
is m raum		19a. Informant's Name/Relationshi						, City or Town, State, Zip	c Code)
itam 27 r othar tra		Lois Lambros	Daughte		0 Roberts				
f itar		20a. Method of Disposition	Domewal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other place	(e) Oct	ober	20c. Location - City or T	own, State
Important: Il any injury o once.		1 Substitution 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	o ∟Hemovai irom State ecify)		vn Cemetery	1 000		Dundalk,MD.	
orta inju		21. Signature of Funeral Service Li		20	22. Name and Addre				
any ir		Mothoris	11/2	moll	Connelly I	uneral H	lome Of D	undalk, P.A undalk,Md.	21222
ysician and edical prize	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of): STIVE s a consequence of): S a consequence of): HYRGID	MEAR	RT FAI	LUZE		
ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify) □			23d. Date of delive Month	Day Year
sign d be	by	Part II. Other significant condition	s contributing to death t	but not resulting in th	e underlying cause giv	en in Part I.		acco use contribute to t is 2 □ No 3 □ Prot	_
2 2	Completed	<u> </u>					24a. Was a autops perform	y prior to co death?	ppsy findings avail mpletion of cause
ticat or, pa		OF Was again referred to medical				20 51 15		No 1□Yes	212 No
recto	Be	25. Was case referred to medical examiner?	Hospital:		oth	ar /	ith (Check only on		
After this tuneral dii	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju	ury 28b. Tim	e of 28c. Injur	4 Wursing H	ome 5 ☐ Reside	nce 6 Other (Specific winjury occurred	(y)
To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	2 Accident investigated as Suicide 6 Could not determine	t be 28e. Place of In	jury - At home, fam. tc. (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Rura , State)	al Route Number,
a Funaral etely filled	dical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel E:	Physician: To the best keminer: On the basis of and manner st	of examination and/o	eath occurred at the tir r investigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as s ite and place, and due to	tated. the cause(s)
d ld ld	Me	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Month,	Day, Year)
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1 8		* XIIIIIIET	I Juli	KG MD	1) 2	4/100		WITIUS	
1 8								, ,	
28		30. Name and address of person w	ho completed cause of	death (Item 23a) (Ty	pe, PON	Α	11.	2 0 (0)	2
4		30. Name and address of person w Willes K 31. Date filed (Month, Day, Year)	18Kg 21	death (Item 23a) (Ty GKEL rar's Signature	Pace	Diente	ell 4	2/22	-2

			1 - For Stata Registrar			Marylar	nd / Depa		t of H	ealth a	and M		giene leg. No. 0	Щ.	31558
н	Physici	ian	Decedent's Name (F		ast)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi	cal	Marguerite				lu	ner				October	5 20		0025 "
	Examir	ner	4a. Facility Name (If no.		_		1.6.16			Location of			4c. County	of Death	1
	Funeral		5. Social Security Numb	der 6.	Bayn'er /	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	/\	9. Birth	place (State or Foreign
н	Director		212-34-201	3	1□M 2\ F	68		Months	Days	Hours	Min.	8. Date of Birth (Month, Day May 11	1936	Mi	place (State or Foreign (ntry)
	put		Usual Residence of De 10a. State 10	cedent b. County		10c Cit	ly, Town or Lo	antion							101 1-11-61-11-11-
	Aaryla Fshored at	5		Baltim	-										10d. tnside City Limits 1 ☐ Yes 2 🛣 No
	28a-i	rect	10e. Street and Numbe		же	Sp	arrows	10f. Zip					l0g. Citizen of	What Cou	
	3a or	Ö	2825 Lodge		Road				219				US		
	within 72 hours after death with the Maryland ene. than "netural, or Items 23e or 28e-1 show te M. dical Ex., ither, was the multiped at	by Funeral Director	11. Marital Status		12. Was Decede Armed Force	nt Ever in U	.S. 13.	Vas Deced	lent of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Amer	ican Indian,
98	or Ite	y Fu	1 Never Married		1 Tes 2	Z No		l ☐ Yes 2		Specify:	1, Fuerto	nicari, etc.)		ck, White y: Whi	
8	hours ural',	q p	3X Widowed 4 □		Year or Date	s:									
5	in 72	oiete	(Specify o		rade completed)		16a. Deced (Give life, L	lent's Usua kind of woi DO NOT us	il Occupa k done di e retired)	tion uring mosi	t of worki	ng	16b. Kind of B	usiness/lr	ndustry
21215-0036	d with giene.	Completed	10 years	ry (0-12)	College (1-4d	or 5+)		itres					Restau	ırant	
	e filed al Hygi I other vent, II	Be C	17. Father's Name (Firs				-			18. Mothe	r's Name	(First, Middle,	Maiden Suman	7e)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury or other treumetic event, Ite M. circl Ex instricted any page.	To	Benjamin Wo					<u>-</u>		He]	len F	Morvath			
Mar	d 2 sh th and th sm treum		19a. Informant's Name									l Route Number		State, Zi	p Code)
	Health tem 27 other to		Susan Weave		Daughter	20b. P					Dunc	lalk,MD.	21222 20c. Location -	City or T	Own State
Baltimore,	Pages nent of I ant: If Ite ury or o			remation 3	Removal from Sta	te Carr	Place of Dispo- emetery, cren red Heart	atory or of	her place	⁾ (Octo	ber			
Ħ	permit. Pag Department Important: I any injury o		21. Signature of Funera									2004	Dundal!		
B	Depa Impo any ir		1 Guts	hom	f Con	nel	ly ?	onnel 110 S	ly Frolle:	unera rs Po	il Ho oint	me Of D Road, D	undalk, undalk,	P.A. MD.	21222
			23a. Part1. Enter the d shock, or heart fai		hplications that caus y one cause on each	ed the deat line.	h. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	ai a		mon									
	Examiner			- 1		as a consequ	uence of):								
		ier	Sequentially list condition if any, leading to immediate. Enter University Cause (Disease or injurior	ons, diate	b. Due to (or a	as a consequ	uence of):								
	cuted nd ransit	Examiner	Cause (Disease or injur	iğ 🔨	c.										
,00	sician and burial-transit		resulting in death) Last		Due to (or a	is a consequ	uence of):								
68760,	physic physic the b	dical			d										
9 X	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Med	IF FEMALE:		23c. If yes, outcon	ne of oregna	incv						22.12		
Вох	atten affor u	cian	23b. Was decedent pre in the past 12 mor	nths?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pre					23d. Dat	e of deliventh	ery Day Year
0	by the a	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	9□ Unknown										
S, D	The law requires that the ste has been signed by th page 2 should be detache	ру Р	Part II. Other significan	nt conditions	contributing to death	but not rest	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did tob	acco use conti	ribute to t	he cause of death?
ord	w require been sig should b		Ho part	val (L	2) labect	my,	Smo	RING				1276	s 2 No	3 🗌 Prob	pably 4 Unknown
Records,	e law r has be	ompleted										24a. Was ar	v p	rior to co	psy findings available mpletion of cause of
E H		Con										perform	ned? _ d	leath?	_
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred t examiner?	to medical	Hospital:				Other			(Check only on			
of	Phys	: To	1 Yes 2 No		28a. Date of In	jury	ER/Outpatient 28b. Time of		4	4 🗀 Nur		ne 5 Reside 8d. Describe ho			(y)
ion	Attending F r death. ector: After by the funera	atior	Naturat 5 2 ☐ Accident	Pending investigation	(Month, E	lay Year)	Injury	М	lc. Injury a Work? 1 🔲 Ye	os 2⊡N			,,		
Division	I or Attendi after death. Director: A I in by the fu	Certification;		Could not l	28e. Place of I	njury - At ho etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (Str City or Town		er or Rura	I Route Number,
	tal or rs afte al Dir	Cer			building,	ato. (opecny	·/					City of Your	, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	Certifying P Medical Exa	hysician: To the bes miner: On the basis and manner:	of examinat	wledge, death tion and/or inv	occurred a	t the time	, date and nion, deatl	l place, a h occurre	nd due to the ca d at the time, da	use(s) and mai te and place, a	nner as si ind due to	tated. the cause(s)
	To th Withir To th Comp	Me	29b. Signature and title	of certifier	/			29c.	License i	number		29	d. Date signed	(Month,	Day, Year)
			· W		8	MD		RE	- s -	-00	0	0	ctober.	. 5	2004
	0		30. Name and address			death (Item	23a) (Type, F								2024 21224 throp, MD
			31. Date filed (Month, D	Gald!		trar's Signat	skily B	MCI	49 4	10	Eest	en Ai	renue	Bal	time, MD
	Sta Registra					uai s Signat	4	han	1.				'		
			UUI	6 2004	t James		for p	your	2/_						

		eath with
Laver, thosard	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with
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	Phy /N Exa	/sician ledical aminer	
Division of Vital Records, P.O. Box 68760,	s the Hospitel or Attending Physicien: The law requires that the death certificate be executed thin 24 hours after death	of the Funeral Director: After this certificate has been signed by the attending physicien and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Modioni Consideration To De Commission In Disciplination

		1 - For State Registrar	State of Ma	aryland	•	artment of I			Mental H	ygiene	004	31559
		Decedent's Name (First, Middle, La.	st)						2. Date of D	eath		3. Time of Death
Physici		Howard	Α.		Tra	avers			October	Day 5	700 -	
/Medio Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town,	or Location	of Death			County of Dea	
		Johns Hopkins Bo	YVIEW MED	deal C	enter	Por	Himi	OVE			NIA	
Funeral		Social Security Number 6. S		e (In yrs. las	st birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of B (Month, D	lirth	9. Bi	rthplace (State or Foreig
Director		212-20-3403	M 2□F	73	Yrs.	WORTS Days	Hours	IVIII).	November	r'27 , 19	30 M	
pus *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	neation						10d. Inside City Limit
laryli sho	ក	Md Baltimo	ro		ounda.							1 ☐ Yes 2 ▼N
28a-i	ect	10e. Street and Number	7.0		/urida.	10f. Zip Code				10a Citiz	en of What C	1
with	ā	2003 Codd Avenue				2122	22			US		ountry?
be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f show event, ir a Medical Examinan must be notified at	Funeral Director	11. Marital Status	12, Was Decedent	Ever in U.S.	13.	Was Decedent of H	Hispanic O	rigin? (Sp	ectv Yes or N			erican Indian,
r iter	Ξ	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🕱			If Yes, specify Cub	an, Mexica	an, Puerto	Rican, etc.)		Black, Whi	
ai', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify	r.		5	Specify: W	hite
n 72 hours "natural", edical Exe	Completed	15. Decedent's Ec (Specify only highest gra			16a. Dece	dent's Usual Occup kind of work done	pation	et of work	ina	16b. Kin	d of Business	s/Industry
d within 7; glene. ir than "n If e Medi	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	d)	SI OI WOIK	uig.			
ygien Perth	S	10 years			Sto	one Mason					struct.	ion
tal H d oth	Be	17. Father's Name (First, Middle, Last)							e (First, Middle		umame)	
should and Men marke umatic	ဥ	Lester Travers							Keste:			
and is in		19a. Informant's Name/Relationship (ng Address (Street						Zip Code)
1 and 1ealth sm 27 ther tr		Doris E. Sylvia 20a. Method of Disposition	wife	20h Plac		Codd Ave		Duno	lalk, Md			7. 0
Pages nent of H int: if ite		1 ☐ Burial 2 🎇 Cremation 3 ☐				sition (Name of matory or other place		Octo			ation - City or	
t. Pertiment		'4 □ Donation 5 □ Other (Specify	Milking Value of	Dayv		Crematory			2004			City,MD
permit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hyglene. Importent: if item 27 is marked other than any njury or other traumatic event. If a Migon.		21. Signature of Funeral Service Licen	C. Com	ella	22	Name and Addre Connelly 7110 Soll	Funer ers I	ral H Point	ome Of Road,	Dunda Dunda	alk,P.A	A. 21222
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death.	Do not ent	er the mode of dyir	ng, such as	s cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Stuge	YEN	al disea	ise					Onset and Death
/Medical		resulting in death)	Due to (or as a		nce of):							(or initially
Examiner		Sequentially list conditions	b. Prostat	e ca	ncer							13 months
D #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a	4		10						1.5 A.
cate be executed by sicien and the burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Scher			myopati	14					4 months
cate be executed physicien and the burial-transit			Due to (or as a	a consequer	ice oi).							
physic the	dicai		d									-
w requires that the death certific been signed by the attending should be detached for use as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy	v					20.	d Data of dal	
atter I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 🗌 Fetal de	ath 3	Ectopic pregnancy Other (specify)	1			23	d. Date of del Month	Day Year
y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							A.		
that	by Pi	Part II. Other significant conditions co	ontributing to death bu	ıt not resultir	ng in the ur	nderlying cause giv	en in Part I	l.	23e. Did 1	tobacco use	contribute to	the cause of death?
n sign	g p	Coronary disease	Type 21	niabe.	1051	Hypothyr	610(15)	m	1 🗆	Yes 2□	No 3 Pr	obably 4 Unknown
w rec	Completed	J	•						24a. Was	an	24b. Were au	itopsy findings available
sicien: The law s certificate has b lirector, page 2 s	mc								auto	psy ormed?	prior to death?	completion of cause of
en: T	e C	25. Was case referred to medical					26 Place	a of Death	1 □ Yes Check onl 0	2 No	1 🗆 Yes	2 X No
Attending Physicien: The law requires that the death certific death, redeath, redeath, art death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	OB	examiner?	Hospital:	nt 2∏ER	/Outpatien	3 DOA Oth			ne 5□ Resi		Other (Spe	ciful
g Phy er thi	n:	27. Manner of Death	28a. Date of Injury	y 28	b. Time of	28c. Injun	y at	-	28d. Describe			ыіу)
ndin ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	Worl M 1 □		No				
Atte ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home	, farm, stre	eet, factory, office	-	1	28f. Location (City or To	Street and N	lumber or Ru	ıral Route Number,
s after safter s	Cert	4 - Homodo	Bolidary, etc.	. (Specify)					City of Tol	wii, Siale)		
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier 1X Certifying Phy (Check only one) 2 ☐ Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination	dge, death and/or inv	occurred at the timestigation, in my op	ne, date an pinion, dea	nd place, a oth occurre	and due to the ed at the time,	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s)
Vithin Fo the	¥ e	29b. Signature and title of certifier	1			29c. License	number			29d. Date s	igned (Month	n, Day, Year)
,,,,,		Nac 1. 6	M. MI			P	1485	1		Octobe	r 5	2004
20		30. Name and address of person who o	ompleted cause of de	ath (Item 23	a) (Type, F	Print)						
10		Valeriani R. Be	act, MD.	4940	Ea	stern Av	enve	, 1/3E)	1 timor	PIMI	0 212	24
Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		4 .						
Registra	ar	66T 0 0 0004	100	00 1	L,	Ana Hall						

DHMH 17 Rev 1/2001

OCT 0 6 2004

ORIGINAL

William Thompson Baltimore, Maryland 21215-0036

> Pnysi /Med Exan

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar AMEND ITEM	#20 PER FH G 8	36 9708	φa o f ηDeath	Reg.	No.2004	3/560
vsician	Decedent's Name (First, Middle, La	(st)	T		2. Date of Death Month	Day Year	3. Time of Death
edical	VVIIIONY	Inompse	$n \cup 1$	y, Town, or Location of De	5-eptem.	20 50, 200 4c. County of Death	10.0-1
niner	4a. Facility Name (If not institution, given GOOD GAWAN)	an Hospital	40.0	altimove	Jan 1	NA	ı
I	5. Social Security Number 6. S	Gex 7. Age (In yrs. Ia	Month	ler 1 Year If Under 24 H	Irs. 8. Date of Birth lin. (Month, Day, Ye	ar) 9. Birth	place (State or Foreign
	Usual Residence of Decedent	5/	Yrs.		Sept. 11,1	947 1110	aryland
	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Directo	Maryland N/	4	saltin	nore			1 XYes 2 □ No
급	1741 Pro K	Avo.	TOI.	Zip Code	log.	Citizen of What Cou) }
Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		cedent of Hispanic Origin? Decify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ameri Black, White	
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 201 No		2 No Specify:	isito riidari, did.)	Specify: D	(etc.
led b	15. Decedent's E		16a. Decedent's U	sual Occupation	16b.	. Kind of Business/Ir	ndustry
Completed	(Specify only highest grant (0-12)	College (1-4or 5+)	(Give kind of life, DO NO	work done during most of v use retired)	working	1 1	
S	17. Father's Name (First, Middle, Last		Lak	over	lame (First, Middle, Maid	ity Ge	Duernmen
To Be	William T	hamosan	Sc	Pe	CALLA	Tohac	00
-	19a. Informant's Name/Relationship	Type, Print) (Sister)	19b. Mailing Addre	ess (Street and Number or	Rural Route Number, Cit	y or Town, State, Zi	p Code)
	Ms. Lorrain	ie Harris	14 E.	ranklin	St. 303	Balto	Md. 2120
	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	netery, crematory of	r other place)	Date 20c.	Location - City or T	own, State
	* 4 □ Donation 5 □ Other (Special Service)Lice	0112		Crematory and Address of Fallity	or or tank	Salto.	Irla.
	Descepti	L Rus	1/3959	h, L, Russ	Fuperal	Home	1216
	23a. Part I Enter the disease, or com shook, or heart failure. List only	plications that caused the death, one cause on each line.	Do not enter the m	ode of dying, such as card	liac or respiratory arrest,	11()11 god	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	PCF	PNE	UMON IA			Onset and Death 2 O day
	resulting in death)	Due to (or as a conseque	ence of):				17 4000
Je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):				1-1 Jeage
tamin	Cause (Disease or injury that initiated events	c					
ω	resulting in death) Last	Due to (or as a conseque	ence of):				
dlc		d.					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Date of deliv	rery
sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea				Month	Day Year
	Part II. Other significant conditions		ting in the underlyin	r cause given in Part I	23e Did tobacc	o use contribute to t	the cause of death?
d by				, cause grown are	1 ☐ Yes		bably 4 Unknown
ompleted					24a. Was an	24b. Were auto	opsy findings available
Com					autopsy performed?		ompletion of cause of
Be	25. Was case referred to medical examiner?	Hanning /			eath (Check only one)		
2	1 ☐ Yes 2 ☐ No 27. Man or of Death		R/Outpatient 3 28b. Time of	OOA Other: 4 Nursing	Home 5 Residence		fy)
atlon	1 ⊇Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No		,0.7 00001100	
2	3 Suicide 6 Could not be determined		ne, farm, street, fact	ory, office	28f. Location (Street City or Town, Sta		al Route Number,
1	+ _ / lonnicide				, 0, 101111, 016	/	
Certification;							
edical Certifi	29a. Certifier 1 Certifying Pl	nysician: To the best of my know miner: On the basis of examination and manner stated.	ledge, death occurre on and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ice, and due to the cause corred at the time, date a	(s) and manner as s and place, and due to	stated. o the cause(s)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINION AIVEN SCOLL LOCK BUYEN BIVE BIVE BALLIMORE MD 21239

31. Date filed (Month, Day, Year)

OCT 0 6 2004

MES 000

October 4, 2004

October 4, 2004

OCT 0 6 2004

OCT 0 6 2004

	c	L	riease	State of A			artment of h					
		-	For State	State of IV	narylari		rtificate of			Reg. N		21551
			Registrar 1. Decedent's Name (First, Middle, La	nst)					2. Da	ate of Death	1000	3. Time of Death
Н	Physicia	an	Dorothy	·			Taylo	70		onth D Hensber	29 200	W 12:37M
>	/Medic Examin		4e. Facility Name (If pot institution, gi	ve street and number	7)						c. County of De	ath
		Ψ.	the Johns A	60Kins	HOSPI	tial-	Bahi	FIMO		44	N/A	
	Funeral		Social Security Number 6.	5	ge (In frs. I		Months Days	If Under Hours	Min. (M	ate of Birth footh, Day, Yea	9. Bi	rthplace (State or Foreign Country)
<	Director	-	238-64-1974 Usuel Residence of Decedent	X	64	. Yrs.			DE	C. 27,	1939 NO	RTH CAROLINA
	land ow		10a. State 10b. County		10c. City	, Town or Li	ocation					10d. Inside City Limits
	Mary Ind	ţō	MD. N/A			BALT	IMORE					11∕ Yes 2 □ No
	or 28s	Director	10e. Street and Number				10f. Zip Code		21221	10g. C	itizen of What C	Country?
	72 hours after death with the Maryland Insturet; or theme 23s or 28s-f show dical Examiner must be notitied at	ai	1501 ELRINO STRE				<u> </u>		21224		U.S.A.	
	tams	nue	11. Marital Status	12. Was Deceder Armed Forces	s?	S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Or an, Mexica	igin? (Specify Y n, Puerto Rican	es or No- , etc.)	14. Race - Am Black, Wh	
36	rs afte	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Tyes 2 If Yes, Give Year or Dates	Λ		1 ☐ Yes 2 X No	Specify.	:		Specify:	WHITE
21215-0036	2 hou	ed	15. Decedent's 8	Education		16a. Dece	dent's Usual Occup	oation	at of working	16b.	Kind of Busines	s/Industry
215	hin 72	pie	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	kind of work done DO NOT use retire	d)	st or working		ELIC ON	LTIDDI C
	filed within Hygiene. other then "	Completed	12				CHEF	10.11.1	er's Name (Firs		EALS ON	WHEELS
pu	tal H	Be	17. Father's Name (First, Middle, Las WILLIAM WILMOUTH						TH UNKN		en Sumame)	
Maryland	should nd Men marks amatic	ဥ	19a. Informant's Name/Relationship			19b. Mail	ing Address (Street				or Town, State,	Zip Code)
Mai	d 2 sl th an t7 ls r traur		DAVID TAYLOR/SON			1	BRIARWOOD					
	Hear tem		20a. Method of Disposition		1 0	lace of Displantery cre	osition (Name of matory or other pla	ca)	Date	20c.	Location - City of	r Town, State
E O	Pages nent of ent: If it		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			LAWN	CEMETERY		10/04/0			, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or itams 23a or 28a-f show ampringing or other traumatic svent, the Mardical Examiner must be notified at angle.		21. Signature of Funeral Service Lice	ensee		2	2. Name and Addre	ss of Facil	ity CHARL	ES S. Z	EILER &	SON, INC.
<u>m</u>	88118	7 1	Jestica +	100KV							, MARYL	AND 21224
Ę			23a. Part1 Enter the disease, or conshock, or heart failure. List only	mplications that caus y one cause of each	ed the death line.	n. Do not en	ter the mode of dyl	ng, such as	cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 5CPS						· <u>-</u>		24 hours
	/Medical Examiner		1 doubling in doubly	Due to (or	as a conseq	uence of):						79 hours
		er	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	b. Dua to (or	as a consag	uence of):						74 10013
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	chron	ס שוו	lecho	MIT					20 year
o,	e be executed /sicien and e burial-transit	Exa	resulting in death) Last	Due to (or a	as a conseq	uence of):						
3760	ate be hysici the bu	lcal		d								
K 68	ertific ling p	Mec	IF FEMALE:	23c. If yes, outcon	ne of preons	nov					23d. Date of d	
Вох	death certificate be attending physical for use as the t	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	I death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		The state of the s	Month Month	Day Year
P.O.	0 0 0	Physician/Medi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9☐ Unknown			(-), // _					
	that the	by Pr	Part II. Other significant conditions	contributing to death	n but not res	ulting in the	underlying cause gr	ven in Part	t. 2	3e. Did tobacce	use contribute	to the cause of death?
rds	w requires been sign should be									1 🗌 Yes	2 X No 3□1	Probably 4 Unknown
006	m so cu	piet							2	4a. Was an autopsy	prior to	autopsy findings available completion of cause of
of Vital Records,	The ate h	Completed							1	performed? ☐ Yes 2 🗶 1	death?	s 2 No
/ita	cian: Th	Be	25. Was case referred to medical examiner?	Hospital:			0.	hac	e of Death (Che			-
of \	Physician: this certific ral director,	1.	1 ☐ Yes 2 🗶 No 27. Manner of Death	28a. Date of I		ER/Outpatie	nt 3 DOA	4 🗆 N		5 Residence Describe how in	6 ☐Other (Sp jury occurred	pecify)
	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigat	(Month, i	Day Year)	Injury	Wo	irk?]Yes 2 []No			
Division	Attending or death.	ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At ho	ome, farm, s	treet, factory, office			ocation (Street lity or Town, Sta		Rural Route Number,
Ď	s after s after el Dire	Certification;	4 Homicide	building,	etc. (Specif	y)				my or rown, or		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only 2 Medical Ex	Physician: To the be aminer: On the basis	est of my kno	wledge, dea	th occurred at the t	ime, date a opinion, de	nd place, and di ath occurred at	ue to the cause the time, date a	(s) and manner and di	as stated, se to the cause(s)
	To the h within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner			29c. Licen				Date signed (Moi	
\	To To Cor		Devide R	in, mi)			- OC	∞)	•	29,2004
	h		20 Name and address of person wh	o completed cause of	of death (Item	1 23a) (Type				94		7 1
	9		30. Name and address of person who Zennifur Pru, mb;	JOHNS HOP	ok; ne t	lospital	Doctors L	ourge!	, 600 N. (work Str	ut; Balto	mar, md 21287
	Sta	ate	0.1.00.1.1.1									
	Regist	rar	OCT 0 6 2	004 50	mes	19	Sport	2				
O1	INALL 17 Day 1/2	1001					*					

MiEgstaff, Nadhaniel
■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		Please	State of Ma				. Ensure All Health and M	-		•	
		1 - For State Registrar	State of Mi	aryland		rtificate of		ieiliai ny	Reg. No	a 670 mm 1	31562
		Decedent's Name (First, Middle, L.	ast)				-	2. Date of De	eath		3. Time of Death
Physicia /Medic		Nathaniel	Barnett		Wagst	aff		Month OCH Ob	er l	2004	lOa.m. ™
Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	or Location of Death			. County of Dea	th
		Mercy Hosp			-44:44 1 3		imore If Under 24 Hrs.	(5)		N/A	
Funeral Director		5. Social Security Number 6. 242-46-1191	Sex 7. Ag	90 (In yrs. Ia 72	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D	ay, Year,		hplace (State or Foreign buntry)
		Usual Residence of Decedent						7 30) 1;	932	N.C.
nylanc how	L	10a. State 10b. County	*	10c. City,	Town or Lo	cation					10d. Inside City Limits
Be-1 s	Director	MD N/	Α		Balti	more					1√XYes 2 No
vith th	Dire	10e. Street and Number			Apt. 103	10f. Zip Code			10g. Ci	tizen of What Co	ountry?
eath v	Funeral	400 N. Ais	quith Stre				21202	ody Vac or N		USA 14. Race - Ame	rican Indian
fter d	Fun	1 Never Married 2 Married	Armed Forces?				Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		Black, White	
be filed within 72 hours after death with the Maryland half lygione. A other than "natural", or items 23a or 28e-f show event, the Madical Exertiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2☑No	Specify:			Specify: Bl	ack
72 hc natuu	Completed	15. Decedent's I (Specify only highest g			(Give	lent's Usual Occup	during most of worki	ng	16b. K	(ind of Business/	Industry
han Pan	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retire	,	•			
Hygie Hygie thert		10th 17. Father's Name (First, Middle, Las	N/A		La	<u>ndscapin</u>	G 18. Mother's Name	(First Middle	Maider	Various	
d be 1 ental l sed o	o Be		•	gstafi	F		Lula	(i mai, maaid		Barnett	
shout nd Me mari	O_	19a. Informant's Name/Relationship)		g Address (Street	and Number or Rura	I Route Numb			Zip Code)
alth a		Henry Wagstaff-	son		199	Pittston	Circle O	vings M	ills	MD 2	1117
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Bemoval from State	Cei	nce of Dispos metery, cren	sition (Name of natory or other pla	сө)	ate		ocation - City or	Town, State
Pag ment ent: t		`4 □Donation 5 □Other (Spec		Mt.		el Cemet		/2004	Bal	timore	MD
permit. Pages 1 and 2 should be filed within 72 bearund to filed within 72 bearunds by grantal Hygiene. Importent: if item 27 is marked other than "n eny injury or other treumatic event, Ite Madignee.		21. Signature of Funeral Service Lice	ensee		22	. Name and Addre	ess of Facility MAI	RCH FUN	ERAL	HOME-E	AST
		23a. Part1. Enter the disease, or co	pwar	the death			orth Aveni			re, MD	21202
		shock, or heart failure. List onl	y one cause on each lin	ne.	DO NOT ONE	er the mode or dyll	ng, such as cardiac c	r respiratory a	rrest,	j	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a Due to (or as	D 60 2.	type .	Canh					
Examiner				a conseque	31100 01).						
/ 7 = =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
be executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
be exician g		resulting in death) Last	Due to (or as	a conseque	ence or);						
The law requires that the death certificate be extite has been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Medical		d								
eath certifics attending pl	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deli	verv
death e atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify) _	/ 			Month	Day Year
at the de by the a	hys	9 🗆 Unknown	9∐ Unknown								
res that igned to be deta	ρχ	Part II. Other significant conditions			- (iderlying cause giv	en in Part I.			_	the cause of death?
w require been sig should b	eted	(5/13/13)	136 17	ent	(/	(1.07)		10'	Yes 2	□No 3□Pro	obably 4 Onknown
e law has b	Completed							24a. Was		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
n: The I ficate ha	e Co	25. Was case referred to medical						1 Yes	2 No		2 No
Physicien: The this certificate if ral director, page	o Be	examiner?	Hospital: 1 ☐ Inpatie	int 2∏F	R/Outpatient	: 3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hon			6 MOther (Spec	in hospice
g Phy er this	Liu	27. Manner of Death	28a. Date of Injur (Month, Day	v 2	28b. Time of Injury	28c. Injur Wor	y at 2	8d. Describe I			11) 1103/100
ath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate	on	7 1021/	піцагу		Yes 2 □No				
or Atte fer de irecte n by t	Certification:	3 Suicide 6 Could not determined		ury - At hom c. (Specify)	ne, farm, stre	et, factory, office	2	8f. Location (S City or Tox			ral Route Number,
pitel o		29a. Certifier 1P Certifying P	huginian. To the best of	of mar language	lades death						
24 hos 24 hos Fun etely	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination	n and/or inv	estigation, in my o	ne, date and place, a pinion, death occurre	d at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	Me	29b. Signature and title of certifier	^			29c. Licens	e number			e signed (Month	
			my or	0		DHI	0854		10	11/20	04
/		36 Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, F	Print)	0			1 -	
Co		21 Date filed (Month Day Your)	berg 30	1 S	1 Pa	ULPL	· Daltin	nore	mo	512 1	20
Sta Registra	_	31. Date filed (Month, Day, Year) OCT 0 6	22. Registra	a s signatu	K	perte					
		00100	LUUT JUL		W /						

AKC	3		For Stata Ragistrar		State of Man		artment of rtificate of			gien Rag. N	0. 65	01560		
	٥	7.76	Decedent's Name (First, Middle, Last)	***				2. Date of De			3. Time of Death		
	Physici /Medic		DONALD	CORD W	ILSON						1. 2004	12:55 P M		
>	Examin		4a. Facility Name (If n				4b. City, Town,	or Location of D	eath	40	c. County of Death			
			Bon Secou				Baltimo					N/A		
	Funeral		5. Social Security Nun	nber 6. Sex	M 2□F 7. Age (/	n yrs. last birthday) Yrs.	If Under 1 Year Months Days		Ain. (Month, Da	ay, Year	9. Birth	place (State or Foreign intry)		
	Director		213 13 C	9418	31				JUN.25	1.	9/3 MAR	YLAND		
	/land			Ob. County	10	Oc. City, Town or Lo	cation					10d. Inside City Limits		
	Mar.	to	MD.	N/A		BALTI	MORE					1 ☐ Yes 2 ☐ No X		
	or 28,	Director	10e. Street and Numb				10f. Zip Code			10g. C	itizen of What Cou	intry?		
	238 c	aic	808 N. I	FULTON A	VENUE		21	217		U.	S. OF	Α		
Maryland 21215-0036	72 hours after death with the Maryland natural, or Itams 23a or 28a-1 show disal Examinant be notified at	by Funerai	11. Marital Status 1 Never Married 3 □ Widowed 4	2 Married	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1☐ Yes 2\\\ No		? (Specify Yes or No uerto Rican, etc.))-	14. Race - Ameri Black, White BLACK Specify:			
5-0	n 72 ho "natur	Completed	(Specify	5. Decedent's Educ	ation completed)	(Give	dent's Usual Occu	during most of	working	16b. F	Kind of Business/li	ndustry		
21	d within giene.	ig.	Elementary/Second		College (1-4or 5+)	SA	RET CRO	PER	•		FARM			
121	Total Control of the		UNKNOWN 17. Father's Name (Fi		NKNOWN			19 Mother's	Name (First, Middle	Maida				
anc	e d d	Be	RUSSEL	DAVIS						, Maidel	ii Sumame)			
Ñ	should ind Men s marke umatic	2	19a. Informant's Nam		e. Print)	19b. Mailir	no Address (Stree	MARTH	A WILSC r Rural Route Numb		or Town State Zi	p Code)		
Ma	and 2 she salth and n 27 is m		CYNTHIA		(SISTER)		PARKW					21217		
ore,	一工商品		20a. Method of Dispo	sition		20b. Place of Dispo	sition (Name of		Date	20c. L	MORE, MA	own, State		
Baltimore,	Pagnent ment ant: I		1 Z Burial 2 Cremation 3 Removal from State KING MEMORIAL PARK 10/8/04 BALTIMORE, MARYL. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
Bal	permit. Departimportimporti			LEWI:	S T. GWYN	N LE	WIS T.	GWYNN	FUNERAL			15-6393		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. AMELICATION											
	Physician		disease or condition	nal _ a.	Asol	usui a						Onset and Death		
	/Medical Examiner		resulting in death)		Due to (or as a c	onsequence of):	0		1,					
	- 1	<u></u>	Sequentially list cond if any, leading to imm	litions, b.	Due to (or as a c	onsequence of):	800	a ko	ilus					
	ted nsit	nin	cause. Enter Underly Cause (Disease or in	ring	220 10 (01 40 40	3								
·	execun and and ial-tra	Examiner	that initiated events resulting in death) La	st C.	Due to (or as a c	onsequence of):								
68760,	fficate be executed g physician and as the burial-transit	edicai		€ d.										
_	±= 00 €	edi												
Вох	death certiff e attending id for use as	N/ue	IF FEMALE: 23b. Was decedent p	regnant	ic. If yes, outcome of p		Ectopic pregnanc	°v.			23d. Date of deliv	*		
O. B	0 0	Physician/M	in the past 12 m 1 Tyes 2 1		4☐Pregnant at tim 9☐ Unknown		Other (specify)	-,			Month	Day Year		
P.(that the	Phy	9 Unknown	ant conditions cont	ributing to death but r	not resulting in the u	nderlying cause o	wen in Part I	23e Did t	obacco	use contribute to t	he cause of death?		
ds,	es De	d by	raitii. Othar signino	ant conditions com	ributing to death but i	iot resulting at the d	indenying cause g	ivon in raiti.	1 🗆		No 3□Pro			
00	w requir s been si should	iete							24a. Was	an	24b. Were auto	ppsy findings available		
Vital Records,	The lav	Completed								psy ormed? 2 No	death?	mpletion of cause of		
ā		0	25. Was case referre	d to medical				26. Place of	Death (Check only		7			
of V	nysic nis ce direc	ToB	1 XYes 2 □ N	o Ho	ospital:	2√€R/Outpatien	t 3 DOA	ther: 4 🗌 Nursin	ig Home 5 ☐ Resi	dence	6 ☐ Other (Special	(y)		
			27. Manner of Death 1. □Natural	5 Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Inju	ary at ork?	28d. Describe	how inju	ry occurred	· 200 = L'		
Sio	Attending r death. actor: After by the fune	cati	2 Accident 3 ☐ Suicide	investigation 6 Could not be	10-1-0	+ (-113]Yes 2,ASNo	Deroce	secl	Chehod a	Hull Cally		
Division	of or Attendate after death	Certification:	4 Homicide	determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (City or To	Street a. wn, State	nd Number or Run			
	Hospital or 24 hours afte Funeral Dira tely filled in t		20a Codifice 1	Cartifula - Dhua	laine. To the best of	Haul			1808 N	tult		HO MDZ1217		
		edical	29a. Certifier 1 (Check only 2 one)	Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	vestigation, in my	opinion, death o	ccurred at the time,	date an	o, and manner as s d place, and due t	the cause(s)		
	To the Hos within 24 h To tha Fur completely	Me	29b. Signature and ti	le of certifier	1	Λ	29c. Licen	se number		29d. Da	ite signed (Month,	Day, Year)		
	- > - O		1	VIA	1/	N	0.C.I	M.E.		Oc	tober 2,	2004		
			30. Name and address	s of person who cor	inpleted cause of deat	h (Item 23a) (Type,	Print)							
	Ы		S.R	HOG	AN			on Stree	et, Baltin	ore	Marvla	nd 21201		
:	Sta Registr		31. Date filed (Month)	Day, Year)	32. Registrar's	Signature	4 6	_	,		,1			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,00	0.5		1 - For State Registrar	State of Maryla	•	artment of trificate of			2001	31561.
			Registrar Decedent's Name (First, Middle, Li	est)		Timouto or	Doutin	2. Date of Death	g. No. U U G	3. Time of Death
	Physicia	n	JAMES	R. WOLFE	JR.			Month October	Day Yeer	12:40 P M
	/Medic		4e. Facility Name (If not institution, gi		J.N. •	4b. City. Town.	or Location of Deal		4c. County of Dee	
	Examin	er	84 N. Old Mill E			Annap			Anne Ar	
	Superal				rs. last birthday,	If Under 1 Year	If Under 24 Hrs			hplace (State or Foreign
и	Funeral Director			1MM 2□F 8	2 Yrs.	Months Days	Hours Min	Nov. 16	.1921 Ma	aryland
			Usual Residence of Decedent							
	nylan how		10a. State 10b. County		City, Town or L					10d. Inside City Limits
	a Ma	cto	Maryland Anne	Arundel	Ar	nnapolis				1 ☐ Yes 2 No
	ith th	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a	Iai	84 North Old Mil			214			U.S.A.	
	tems	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinating Legitilled at	ed t	15. Decedent's E		16a. Dece	dent's Usual Occu	ipation	1	6b. Kind of Business	Industry
15	in 72	plet	(Specify only highest gi	ade completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking		,
212	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Indepe	endent In	ns. Agent		Self-Emplo	yed
	Il Hygi other	Be C	17. Father's Name (First, Middle, Las	")			18. Mother's Na	me (First, Middle, M	laiden Sumame)	
<u>lar</u>	Mental Arked o	ToE	James R. V	<i>l</i> olfe Sr.			Na	nnie	Gail	
Maryland	2 sho and h is me		19a. Informant's Name/Relationship	-	19b. Maili	ng Address (Stree	t and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
	1 and 2 Health tem 27 i		Francis E.S. Wolf				Island,		efield N.H	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [b. Place of Dispersion cemetery, cre 	osition (Name of matory or other pla	ace)	Date 2	Oc. Location - City or	Town, State
Ē	Pag ment ant: I ury o		`4 □ Donation 5 □ Other (Spec	fy) Ba	ayview (rematory	10-0	04 – 04 I	Baltimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exercinet must be notified at 900.8.		21. Signature of Funeral Service Lice	nsee	Mr.	2. Name and Addr	ess of Facility	uneral Hor	те Р Δ	
	70 E 9 9		Tun &	rougus					me P.A. a, Marylan	d 21122
3			23a. Part . Enter the disease, or con nock, or heart failure. List only	one cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Hyperten	Sive A	therosci	evotic li	avoliovasc	ulas Disas	2)
8	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					
В	Examinic:	<u>_</u>	Sequentially list conditions,	b	roquence of:					
	led sit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	500 10 (0) 03 0 0011	304001100 01).					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a con:	sequence of):					
760,	ate be executed hysician and he burial-transit	calE		o d						
687	ficate physics the			0.						
Вох	nding use a	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Te			23d. Date of del	ivery
Ď.	death e atte d for	icla	in the past 12 months?	1 Live birth 2 F 4 Pregnant at time of		_Ectopic pregnand _Other (specify) _	cy 		Month	Day Year
P.0	t the by the lache	Physician/Med	9 ☐ Unknown	9□ Unknown						
	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as the	by P	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause g	iven in Part I.		acco use contribute to	S 2
Records,	w require been sign	ed						1 Tes	: 2 □ No 3 □ Pr	obably 4 Dunknown
000	law re as be 2 sho	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Ä		E O						perform	ed? death? □ No 120 Yes	
Vital	artifica ctor.	Be (25. Was case referred to medical examiner?				10.00	ath (Check only one,)	
of V	Physician: r this certific ral director.	ဥ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA		forme 5 Residen	nce 6 □Other (Spe	oify)
n o	afte and		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo		28d. Describe how	v injury occurred	
sio	Attending It death. Ctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not]Yes 2□No	000 1 100		
Division	or At fiter of Direct in by	Ē	4 Homicide determined		it nome, rarm, st ecify)	reet, factory, office	1	City or Town,	eet and Number or Ru State)	irai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier 1 ☐ Certifying P	hysician: To the best of my	knowledge dest	h occurred at the t	me date and place	and due to the co	lea(e) and manner	ctated
	Hos 24 ho Fun etely	dica	(Check only one) Medical Exa	miner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my	opinion, death occi	urred at the time, dat	e and place, and due	to the cause(s)
	o the	Me	29b. Signatury and title of certifier			29c. Licen	se number	290	d. Date signed (Monti	n, Day, Year)
	- s + 0		RAMIN	aclan wd			O.C.M.E.	Oc	ctober 04,	2004
	10	1	30. Name and address of person who		Item 23a) (Type.	Print)	-			
	")		CHROLH A	UAW wd			treet, Ba	altimore,	Maryland :	21201
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Si	gnature					
, '	Registr	ar	OCT A 6 200	1300	K Some	Kis				

ORIGINAL

Please	e Type or Prir	nt in Black Ir	ndelible Ink.	Ensure Al	l Copies	Are	Legib	ole.		
. For	State of Ma	aryland / Dep	artment of He	alth and M	lental Hy	giene)			
1 - State Registrar		Ce	rtificate of D	eath		Reg. No	00	4	3 565	
1. Decedent's Name (First, Middle, I	Last)				2. Date of De			Vaar	3. Time of Death	
Norman W. Wa	alls				Octobe	er 6	, 200	Year)4	1:10AM M	
4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or I	ocation of Death		4c.	County	of Death		
Oakcrest Care C	Center		Baltimore					Baltimore		
Social Security Number 6.		e (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th y, Year)		9. Birthp	lace (State or Foreign	
217-18-1550	1 ☐ M 2 ☐ F	88 Yrs.			Jan.9,	191	6	Mary	Iand	
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City Limits	
		-							1 ☐ Yes 2 ₩ No	
MD Baltim 10e. Street and Number	nore	Baltimore	10f. Zip Code			10a Cit	izen of W	hat Cour	ntry?	
8800 Walther Blv	/d. Apt.120	12	21234			rog. Oil	U.S.		,y .	
11. Marital Status	12. Was Decedent			panic Origin? (Sp	ecify Yes or No				an Indian,	
1 ☐ Never Married 2 💢 Married	Armed Forces?	40	Was Decedent of His If Yes, specify Cuban	Mexican, Puerto	Rican, etc.)		Black	, White,		
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify:	Wr	nite	
15. Decedent's (Specify only highest of		16a. Dece	edent's Usual Occupat a kind of work done du	ion	na	16b. K	ind of Bus	iness/Ind	dustry	
Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired)	ning most of work	,,9		0			
y manager a. co										
17. Father's Name (First, Middle, La Harry N. Wall			1	8. Mother's Name Minnie	F. Mas		Sumame)		
19a. Informant's Name/Relationship Alvina T. Walls			ing Address (Street ar Walther B							
20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specific Property of the Core Propert			osition (Name of ematory or other place) Service Co		/04				own, State / l and	
21. Signature of Funeral Service Lic	ensee Heather	Cain 2	2. Name and Address	of Facility Lec	nard J.				-	
Fleather	(aui		5305 Harfo	rd Road	Baltimo	re,	Mary	l and	21214	
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	10.		such as cardiac o	r respiratory a	rest,			Approximate Interval Between Onset and Death	
disease or condition resulting in death)	a	heniu Was	1 : /						years	
	Due to (or as	a consequence of):								
Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):						-		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
that initiated events resulting in death) Last	c Due to (or as	a consequence of):								
	o d									
	7 1									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)				23d. Date Mont		ny Day Year	
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
Part II. Dther significant conditions	s contributing to death b	ut not resulting in the o	underlying cause given	in Part I.	23e. Did to	obacco u	se contrib	oute to th	e cause of death?	
					101	es 2	XN0 3	B 🗌 Prob	abiy 4 Unknown	
					24a. Was autop		pri	ior to con ath?	psy findings available inpletion of cause of	
						2 N o		Yes	2P1N0	
25. Was case referred to medical examiner?	Hannital		Othor	26. Place of Death	(Check only o	ne)				

MO

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

21234

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OCHW 6th

29d. Date signed (Month, Day, Year)

2004

Physician /Medical **Examiner**

1 - For State Registrar 1. Decedent's i

Physician

/Medical

Director

Completed by Funeral

To Be

Examiner

Funeral Director

Examiner within 24 hours after death.

To the Funarel Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical Completed by Be Certification; To

Medical

Registrar

Cingina 31. Date filed (Month, Day, Year) State

29a. Certifier

1 Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Aatural

2 Accident

3 Suicide

4 Homicide

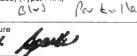
(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wa 1th 8,00 32 Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)



2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

🚌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53115

1 ☐ Yes 2 ☐ No

OCT 0 6 2004 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S UNKNOWN 04-311 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Earnest Hughmanly Woody SEPT. 23, 2004 0544 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ROUTE# 301 NORTHBOUND OF CHADDSFORD BRANDYWINE PRINCE GEORGES 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 1.X M 2□ F Months 65 Virginia Director 083-30-1905 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 27 is marked other then "natural", or items 23a or 28a-f shov treumetic event, the Mccical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10808 Pookey Way 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 XXIO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other then *ns Elementary/Secondary (0-12) College (1-4or 5+) Owner/Driver E.H. Woody Trucking 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Richard Woody Viola Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny injury or other treum 20029. 10808 Pookey Way, Upper Marlboro, MD 20774 Brenda Starks Woody (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 9/28/04 Alexandria, VA 22. Name and Address of Facility
Thacker Brothers Funeral Ho
P.O. Box 185, Scottsville, 21. Signature of Funeral Service Licensee Osellman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à No 3 Probably 4 Unknown 1 Yes Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has death? this certificate 2 No Yes 2 No Division of Vital Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1X Yes 2 □ No 4 Nursing Home 5 Residence Wother (Specify) AT SCENE 28a. Date of Injury (** onth, D, y Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Driver wmilti-vhice collision 1 ☐ Yes 2 No death. investigation 23 104 0500 2 Accident l or Attend after death Director; the f 6 Could not be determined Place o Injury - At hom building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide At home, farm, street, factory, office 28e. filled in by 4 Homicide C within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

ARON 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

nd address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 6 2004

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

24, 2004

SEPT.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of De	eath	Re	g. No.2 0 0 L	31567
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yes	3. Time of Death
	/Medic		RUTH KENNY WOOTEN			October_	3, 2004	2AM
/	Examin	er	4e Facility Name (If not institution, give street and number)		city, Town, or Loc ltimore	ation of Death	4c. County of D Baltim	
	-		Oak Crest Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bir			8. Date of Birth		
	Funeral Director		4014 4015	Yrs. Months Days H	Hours Min.	8. Date of Birth (Month, Day, June 27,	1908 M	Birthplace (State or Foreign Country) lary I. and
	/land	Ì	10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
	Man	ģ	Maryland Baltimore Balti	more				1 ☐ Yes 2 ☐ No.
	⊕ 28 100 100 100 100 100 100 100 100 100 10	E P	10e. Street and Number	10f. Zip Code		10	g. Citizen of What	Country?
	ath w	a	8832 Walther Blvd	21234			USA	
020	permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 14. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes XX No S		cify Yes or No- lican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
5	72 ho	at e	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ing most of working	g 10	6b. Kind of Busine	ss/Industry
12	Arthin Personal Perso	Be Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	Teacher			City of	Daltimona
d 2	Hygie ther t	ပ္	17. Father's Name (First, Middle, Last)		3. Mother's Name	(First, Middle, Ma		Baltimore
an	id be ental ked o	To Be	William Francis Kenny			abeth Mo		
Mary	nd 2 shou lith and M 27 is mar		19a. Informant's Name/Relationship (Type, Print) B.J. Medairy Attorny 2	o. Mailing Address (Street and 104 Courtland A	Avenue To	Route Number, OWSON, M	City or Town, State	e, <i>Zip Code)</i> 21204
Baltimore, Maryland 21215-0020	Pages 1 a ant of Hee nt: If Item	ŀ	1XXBurial 2 Cremation 3 Removal from State	f Disposition (Name of ry, crematory or other place) y Valley Mem (Gar 1		imonium,	or Town, State Maryland
Balti	permit. Departminents Imports any inju		21 Signature of Funeral Sorvice Licensee (Market Length Length Res)	22. Name and Address of	of Facility Mitch	hell-Wiede	efeld Funer	
		1	23a. Part1. Enter the disease, or complications that caused the death. Dor shock, or heart failure. List only the cause on each line.	not enter the mode of dying, si	such as cardiac or	respiratory arres	t,	Approximate Interval Between
U	Physician							Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	re Hocat	+1	112		13711
		-	Due to (or as a	consequence of):				20
	uted d ansit	Medical Examiner	b. Ityperte	consequence of):				of ogos
ó	rtificate be axecuted ng physician and i as the bunat-transit	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	sonsequence ory.				1
68760,	ate be nysick he bu	lical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a context of the context	consequence of):				
ğ	ing pl	₩ Me						
Box	ath co	lan	d					
o.	ha de ched	ysic	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in	n Part I.			ite to the cause of death?
P.0	that the hold by data	Y P	Osteoporosis			1 Tes	2 No 3□	Probably 4 Unknown
Division of Vital Records,	The law requires that the death certificate be assecuted ate has been signed by the attending physician and page 2 should be datached for usa as the burial-transit	Completed by Physician/	·			24a. Was an performe		Were autopsy findings available prior to completion of cause of death?
Ž.	Tha is	E				1□ Yes	2 No-	1 ☐ Yes 2 ☐ No
Ita	lan: artifica ctor, i	Be	25. Was case referred to medical examiner?	26	6. Place of Death	(Check only one)		
>	hysic his ca Il dira	유	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou				ce 6 □Other (S	pecify)
ב	Ing P Aftar t unera	Ö	1 Salatural 5 Pending (Month, Day Year) II	Time of njury at Work?		3d. Describe how	injury occurred	
<u>s</u>	Attending Physician: r death. setor: After this cartific. by the funeral diractor,	Cat	2 Accident investigation 3 Suicide 6 Could not be		2 □ No	of Location (Stre	ot and Number or	Rural Route Number,
	or Attend after death Director: / d in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa	rm, street, ractory, onice	20	City or Town,		Aurai Aoute Number,
_	To the Hospital or Attending Physician: Tha law within 24 hours after death. To the Funeral Director: After this cardificate has completaly filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, d d/or investigation, in my opinio	date and place, an on, death occurred	d due to the cau d at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	othe othe ompk		29b. Signature and title of certifier	29c. License nu		1	Date signed (Mo	
	->-0		Willi m Mussells	7 730	182	00	tuber (1.2004
	\ 0	-	30. Name and address of person who completed cause of death (Item 23a) ((Type, Print)	. 3	. 0		1,2004 MDZ1334
	<u> </u>		WILLIAM RUSSELL 82	300 Welt	Her II h	19 10	erk ville	MD213134
	Star Registra	re.	31. Date filed (Month, Day, Year) OCT 6 2004 32. Figistrar's Signature	Sporte				·

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** OCTOBER 4, 2004 10:48 AM THELMA WILHEMINA WILLIAMS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Yea 6/4/1926 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2XX 78 Yrs. Director 216-20-8741 ARKANSAS Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 le marked other than "natural", or items 23a or 28e-f ehow other traumatic event, the Medical Examirer must be notified at 1 Yes 2XXVo Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 CAROLINE ROAD 21061 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 le marked other than "natural", or Iter 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE 12 ANNE ARUNDEL MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MACY ROBERT THOMPSON LUCILLE CALVERT ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES WILLIAMS - HUSBAND 617 CAROLINE ROAD, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. BAYVIEW CREMATORY 10/4/2004 1 4 ☐ Donation BALTIMORE, MD 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 KELLY GREGORY FINK #M01148 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Delenores 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 Yes 1 Yes or Attending Physicien: 25. Was case referred of medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manuar of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOPRA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

OCT 0 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1^{Pay}2004 7:30 PM Elizabeth Wienecke October Eleanor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7613 Mt. Vista Road Baltimore Co.-Kingsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** January 14 1917 Baltimore Co., MD Director 213 05 6075 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumatic event. It is Medical Examinating in initial at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Baltimore Kingsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 7613 Mount Vista Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2XNo Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) NA Elementary/Secondary (0-12) Unknown Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John C Bartenfelder Elizabeth Langenfelder 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine E Baker (Daughter) 7613 Mount Vista Road Kingsville, Maryland 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Pluportant: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cemetery October 5 2004 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21256 23a. Part1. Enter the mease, or complications the sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ensestive **Physician** Hea-t disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physiclan/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 22 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🔀 🗓 1 Inpatient 2 ER/Outpatient 3□ DQA Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide

Division of Vital Records, P.O. Box 68760,

To the needs after death, within 24 hours after death.

To the Funeral Director: Af

State Registrar

V)

Medical

4 Homicide

(Check only one)

MANIC

29b. Signature and title of certifier

0 6

29a. Certifier

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) ST nombres 6

and manner stated

10 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 2:12 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (seneral Columbia Howard arnto 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 XM 2 F Hours 52 Director 587-66-8619 Sept.1,1952 Mississippi Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Modical Exercises must be notified at MD Howard Columbia 1 ☐ Yes 2X No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 6406 Loring Drive 21045 12. Was Decedent Ever in U.S.
Armed Forces?
12. Yes 2 No 1971
14 Yes, Give
Year or Dates: 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Specify African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1972 "naturai". Americar 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept. of Veterans and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Affairs District Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irrie Wordlaw Aggie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If Itam 27 is any injury or othar trai onca. 6406 Loring Drive, Columbia, Maryland 21045 ace of Disposition (Name of Date 20c. Location - City or Town, State Laura Wordlaw/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park Oct.11, 2004 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Aspiration 6 Day disease or condition resulting in death) /Medical Due to (ovas a consequence of): Examiner deroderm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy ŏ Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 21 No 2 No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours To the Funaral 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Columbia 32. Registrar's Signature 31. Date filed (Mo. State Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Whiting Year **Physician** ottie oct 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital County General Howard Howard Columbia If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 5-40-4793 Director 04/16/19 Georgia Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "naturel", or items 23a or 28e-f show treumatic event, it is Modical Examination was be notified at 1 ☐ Yes 2 X No **Funeral Director** MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11253 B Slalom Lane 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Teacher 4+ Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 end 2 should be ment of Health end Menta lent: If Item 27 is marked Jerry Luck Jemimah Laura Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end Department of Health Importent: If Item 27 any injury or other tru once. 11253 B Slalom Lane, Columbia, MD 21044 of Disposition (Name of Date Date 20c. Location - City or Town, State Albert Whiting/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Oct 5,2004 Laurel, MD * 4 ☐ Donation 5 ☐ Other (Specify) Balt. Wash. Crematory 22. Name and Address of FacilityWitzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bowel **Physician** Ischemic 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hiper tension 1 Yes 2 No 3 Probably 4 Unknown arthritis Rheu matoid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy osteuporosis. 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2Â No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MID. 56531 Oct 1, 2004 Columbia, MD21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10780 HICKOTY tarry Li, 31. Date filed (Month, Day, Year) OCT 0 32. Registrar's Signature State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	Modes in the correction of the		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crematory of	or other place) k Cemetery 10		Location - City or 1	
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P.O.	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	9 Unknown	9□ Unknown					
	Se G	by F	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlyin	g cause given in Part I.	23a. Did tobaco		the cause of death?
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of Vital Records,	law law las be	Completed by	HUPERTENSI	ON			24a. Was an autopsy	prior to c	opsy findings available ompletion of
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Ö	s afte	Certification:	4 Homicide determined	building, etc. (Specify	7		City or Town, St.	110)	
	hour hour uners		29a. Certifier Certifying P	hysician: To the best of my know miner: On the basis of examinat	wiedge, death occurr	ed at the time, date and pla	ce, and due to the cause	(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner stated.					
\	To To	-	29b. Signature and title of certifier	Nann		29c. License number	29d. I	Date signed (Month	, Day, Year)
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	h		30. Name and address of person who	completed cause of death (Item	23a) (Type, Printy)	TRK HEIGT	HT AVE. V.	3 Aero V	ND 21208
200	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		11219	113 11.01		75 07-04
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		State Registrar		Certificate of		Reg	N60 0 0 1	01071
ician		Decedent's Name (First, Middle, La				Date of Death Month	Day Year	3. Time of Death
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niner		4a. Facility Name (If not institution, giv			r Location of Death		4c. County of Deat	
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al or		5. Social Security Number 6. S 068-01-3215 Usual Residence of Decedent	TH OTE	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo June 20,		hplace (State or Fore untry) V York
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Funeral Director	3	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
		14921 Laurel Oaks	Lane	20707	,		U.S.A.	•
era	-	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	ncan Indian,
F.	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2XXVo		an, Mexican, Puerto	Rican, etc.)	Black, White	
2	5	3€Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 210XNo	Specify:		Specify: V	White
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10		John Frederick Wo	lf		Margaret	Mary Far	crell	
	Į	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street	and Number or Rura	l Route Number, C.	ity or Town, State, Z	ip Code)
		Carol Larkin /	daughter 14	1921 Laurel	Oaks Lane	Laurel	Maryland	20707
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		shock, or heart failure. List only Immediate Cause (Final	plications that caused the death. Do not one cause on each line. Stroke	not enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
1		disease or condition resulting in death)	Due to (or as a consequence of	of):				1 month
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EX		resulting in death) Last	Due to (or as a consequence of	of):				
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icla		in the past 12 months? 1 ☐ Yes 2XXNo	4☐Pregnant at time of death	5 Other (specify)			Month	Day Year
hys		9 Unknown	9□ Unknown					
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Ö		25. Was case referred to medical			26. Place of Death	(Chack ask asa)	No 1 ☐ Yes	2[X No
0		examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Othe	ar.		e 6 ☐Other (Speci	4.1
1	- 1	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury		8d. Describe how in		19)
i i		1 XNatural 5 ☐ Pending 2 ☐ Accident investigation			<br Yes 2 □ No			
Certification:		3 ☐ Suicide 6 ☐ Could not b	289. Place of Injury - At nome, far	m, street, factory, office	2	8f. Location (Street	t and Number or Rur	al Route Number,
ert		4 Homicide determined	building, etc. (Specify)			City or Town, S	ta te)	
		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge,	, death occurred at the tim	e, date and place, a	nd due to the cause	e(s) and manner as	stated.
edical		(Check only 2 Medical Examone)	niner: On the basis of examination and and manner stated.	for investigation, in my or	pinion, death occurre	d at the time, date	and place, and due	o the cause(s)
₹		29b. Signature and title of certifier	1	29c. License	number	29d.	Date signed (Month,	Day, Year)
		Van Al ATI			12227		atabas 1	2004
41		30 Name and address of person who	completed cause of death (Item 23a) (43237	0	ctober 1,	2004
		Decrease and address of person who	proton oxedo or death (term 202) (ryp/O, r coll.)				
		Paul Armstrong,	M.D. = 14201 Tauro	l Park Driv	a C111+0	102 Tau-	el, Maryl	20707

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physici		1. Decedent's Name (First, Middle, Last) Oliver Watts	, Jr.					ate of Death		3. Time of Death
/Medic		OLIVER J. WATTS					oc	IOBER	1, 200	12:25P.
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To			f Death		4c. County o	
Funeral	-	7495 FURNACE BRANCH ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	GLEN If Under 1	Year	If Under 2	24 Hrs. 8. D	ate of Birth		ARUNDEL 9. Birthplace (State or Fore
Director		5. Social Security Number 6. Sex 1217-30-6030 7. Age (In yrs. In Security Number 145 M 2 F 66	Yrs.	Months [Days	Hours	Min. SEP	T. 13	Year) 938 1	ARYLAND
\$		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation						10d. Inside City Lim
28e-f show	ō		LEN BU							1 ☐ Yes 2√2
28e-	Directo	MARYLAND ANNE ARUNDEL G	LEN DU	10f. Zip Ci	ode			10	g. Citizen of W	
tems 23a or 28e-f show at must be notified at	D	7495 FURNACE BRANCH ROAD		210	60				JNITED :	•
Items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U. Agned Forces? 1.0.5	S. 13. \	Was Deceder	nt of His	panic Orig	gin? (Specify '	Yes or No-		- American Indian, , White, etc.
동생	by Fu	1 Never Married 2 Married 1 Yes 2 No 1 36	Ω-	T⊟Yes 2X		Specify:	, 1 00/10 1 11041	1, 010.7	Specify:	WHITE
"neturel", o		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Decer	dent's Usual (Occupati	ion			6b. Kind of Bus	iness/Industry
e. an "nel	plet	(Specify only highest grade completed)	(Give	kind of work	done du		of working	'	do. Kind of Bus	inessmoustry
Il Hygiene. other than vent, It a M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	INS	TALLER	L				SECURIT	Y SYSTEMS
f Health and Mental Hygiene. item 27 is marked other than other treumatic event, ILAM	Be	17. Father's Name (First, Middle, Last)			1		r's Name <i>(Firs</i> RA SMIT		aiden Sumame)
and Mental is marked eumatic ev	<u>۲</u>	OLIVER J. WATTS, SR.	105 A4:15		7				01	
27 is r r treur		19a. Informant's Name/Relationship (Type, Print) DIANA L. HART/PERSONAL REPRESEN	TATIVE	132	4 C	AMBRI	IA ST.	BALTII	City or Town, S MORE, M	21225
item item			lace of Dispo	sition (Name natory or othe	of	00	CTOBER	4 2	0c. Location - C	City or Town, State
Department of I Importent: If ite any injury or of once.				MATORY			2004		CATONS	VILLE, MD
Departm Importe any inju once.		21. Signatu of Funeral Service Licensee	1 2 K	TRRLEY	A <u>d</u> d R00 1	obie:	FUNER	AL HO	ME P.A.	
8 3 2 2		ou L. Chary								MD 21061
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	er the mode o	of dying,	such as	cardiac or res	piratory arre	st,	Approximate Interval Between Onset and Death
rysician		Immediate Cause (Final disease or condition resulting in death)	Ressa	su t	ter	ron	RHAY	E		Oriset and Deat
Medical xaminer		Due to (or as a consequ	uence of):							
黄	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions).	uence of):							
d ar sit	Exaniner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								1/4
ician and burial-tra		resulting in death) Last Due to (or as a consequence of the consequenc	uence of):							
9 S	Ilcal	d								
ding p	/Mec	IFFEMALE: 230 If you guttoons of promo								
e attending phy id for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of december 2 Fetal 4 Pregnant at time of december 3 Fetal 4	death 3	Ectopic preg					23d. Date Mont	of delivery h Day Year
9 0	ysic	1 Yes 2 No 4 Pegnant at time of the 9 Unknown	Jan 32	JOHNER (Speci	···y)					
een signed by th nould be detache	by PI	Part II. Other significant conditions contributing to death but not rest	ulting in the u	nderlying caus	se given	in Part 1.		23e. Did tob	acco use contrib	oute to the cause of death?
been sig should b								1 ☐ Yes	2 □ No 3	Probably 4 10 Unkno
0 2	ompleted						- 2	24a. Was an autopsy		ere autopsy findings availa or to completion of cause
ate h page	Сош						1	perform	ed? de	ath?
is certificate ha	Be (25. Was case referred to medical examiner?			-		of Death (Che			
this	7		ER/Outpatien		-		1			(Specify)SCENE
After fune	tlon	1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	M 28C	Injury a Work?	at es 2.⊟N		Describe nov	v injury occurre	
after death. I Director: After	fical	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	me, farm, str		-		28f. L	ocation (Stre	et and Number	or Rural Route Number,
= = C	Certification:	4 Homicide determined building, etc. (Specify	1)	, , .			0	City or Town,	State)	
within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier 1 ☐ Certifying Physician: To the best of my kno (Check only 2 ☑ Medical Examiner: On the basis of examinal	wledge, death	occurred at vestigation, in	the time	, date and	d place, and d	ue to the car	use(s) and man	ner as stated.
thin 2 the f	Med	one) and manner stated. 29b. Signature and title of certifier			icense r					(Month, Day, Year)
To Los		Nous Dalle	W.O	250.						•
		menone your some	VU	-	0	.C.M	·E.	OC	TOBER 2	, 2004
		30 Name and addr. s of person who completed cause of death (the-	23a1 /T.	Print\						
D		30. Name and addr his of person who completed cause of death (Item 7AMD BUTD A LLDRETU			nn s	trec	+ D-1.	+im		and 21201

				aryland / Depa					
		1 - For State Registrar		-	rtificate of		, ,	Neg. No.2004	3 5 7 5
Physic	ian	1. Decedent's Name (First, Middle, La	est)		<u>*</u>		2. Date of Dea Month	th Day Year	3. Time of Death
/Medi	cal	Charles M. Wimer 4a. Facility Name (If not institution, give			45 Oib To		october	4 2004	
Examir	ner	North Arundel Ho			Glen Bu	or Location of Death		4c. County of Deat	
Funeral	П	5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Anne Arur	hplace (State or Foreign buntry)
Director		217-20-9399 Usual Residence of Decedent	1 √ □M 2□F	79 Yrs.			5/30/19	925 West	. <u> Virginia</u>
anyland show		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
ne Mai	Director	MD Anne Ar	unde l	Glen Bur	nie				1 ☐ Yes 2 📉 No
with th	Dire	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	untry?
WIMER 1215-0036 within 72 hours after death with the Maryland ane. than 'naturel', or items 23e or 28e-1 show ite Medical Exeminar marker accidited at	Funerai	15 1st Avenue 11. Marital Status	12. Was Decedent	Ever in U.S. 13. \	21060 Was Decedent of H	Hispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Ame	rican Indian.
after or Ite	/ Fur	1 Never Married Z Married	Armed Forces? 1 Yes 2 1	No	f Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spe an, Mexican, Puerto F Specify:	Rican, etc.)		e, etc.
MIMPLE 15-0036 17-0036 17-0036 17-0036 18-0036 18-0036 18-0036 18-0036 18-0036 18-0036 18-0036 18-0036 18-0036 18-0036	d by	3 Widowed 4 Divorced	Year or Dates:						nite ————————————————————————————————————
7 5 ric 2 5 ri	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Business/	Industry
	Com	7	College (1-4or 5		chinist			Harvison-Wa	alker
d fai b	Be	17. Father's Name (First, Middle, Last Charles A. Wimer				18. Mother's Name			
Maryland Az should be fill th and Mental th Tis marked oth traumatic even	2	19a. Informant's Name/Relationship (19b Mailin	n Address /Street	Zoetta		, City or Town, State, Z	Tio Codel
2 = 2 = 2 = 2		Violet Wimer/Spou		I was a				urnie, MD 2	
ges 1 a tof Hear	Н	20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo-		ce) Da	ate	20c. Location - City or	
altimor mit. Pages partment of the portent: If the y injury or of		*4 □Donation 5 □ Other (Special	^(y)	MD Vetera			/2004	Crownsvill	le, MD
Baltimo permit. Pages Department of Importance or importan		21. Signature of Funeral Service L	nspe /	1	. Name and Addre	Sta	_	Funeral Hom	ne, P.A.
		23a. Part1. Enter the disease, or com	plications at cause	he death. Do not ente	111 MOUNT or the mode of dying	tain Rd. P ng, such as cardiac or	asadena respiratory arri	, MD 21122	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause to each in	l'ak					Interval Between Onset and Death
/Medical Examiner		resulting in death)	a. Due to (obs	a consequence of):	0.1				Smorti.
Examine	<u>-</u>	Sequentially list conditions,	b. Due to tras	a office office of	Lolon	can	12		Smorty.
d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nearly that initiated events	200 10 111 20	2 0 110 120 00 01).				1	
Box 68760, == eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
68760, tificate be e: g physician as the buria	dicai		d						
Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certificat ric death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				004 0-11-4 4-1	
O. Bo	iciar	in the past 12 months?	4 Pregnant at		Ectopic pregnancy Other (specify)	/		23d. Date of delin	Day Year
P.O. that the de by the detached	Phys	9 🗆 Unknown	9□ Unknown						
ds, F irres that signed d be de	d by	Part II. Other significant conditions of	contributing to death be	ut not resulting in the un	derlying cause giv	en in Part I.	23e. Did tob	eacco use contribute to	the cause of death?
Division of Vital Records, or Attending Physicien: The law requires that after death. Director: After this certificate has been signed in by the functal director, page 2 should be control to the control of the contr	Completed	Commound	12.70	d	20410		24a. Was at		
II Rec The lav	omp	Ha Al-Ar-	- 5TM				autops	y prior to co ned? death?	opsy findings available ompletion of cause of
f Vital F vysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?	1,000			26. Place of Death	1 Yes 2 (Check only on	No 1 Yes	2 LI No
of V Physic this o	2	1 Yes 2 No 27. Manner of Death	Hospital: Inpatie			4 I Nursing Hom		nce 6 Other (Speci	fy)
On ding th.	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 ∐No	d. Describe ho	w injury occurred	
VISI Atter er dea rector by the	tifica	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, farm, stre			3f. Location (Str	eet and Number or Rur	al Route Number,
Distal or risaft or risal Distal Dist	Cer		building, etc				City or Town	,	
Hosp 24 hor Fune etely fi	edical	29a. Certifier Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examination and/or inv	occurred at the tin estigation, in my o	ne, date and place, ar pinion, death occurred	id due to the ca d at the time, da	use(s) and manner as site and place, and due t	stated. to the cause(s)
Division of To the Hospital or Attending Ph within 24 hours after death. completely filled in by the funeral	Me	29b. Signature and title of certifier	and manner sta	180.	29c. License	e number	29	d. Date signed (Month,	Day, Year)
		A TO	-	MO	D	43977	t	obber 4	2004
in		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, F	Print)	1.1.	B	0	2 101 1
Sta	te	31. Date filed (Month, Day Year)	A) nn Å ² . Regiska	s Signatue	Coules	- i wen	M	w. · W. · C	-1001

			1 - For Amend Item 2	State of Mar per phy G	yland / Dep. 836 10 20	artment of He 104 tas rtificate of D	ealth and M Death		Don No.	/ 1 1 1 1 1	21576
H	Physici	an	Decedent's Name (First, Middle, Last) Hilde) J.	7:	immet		2. Date of De	eath Q_	28-04	3. Time of Death 4:30 A M
No.	/Medic Examir		4a. Facility Name (If not institution, give		۷.	4b. City, Town, or L	ocation of Death	0)/2	4c.	County of Deatl	
1	Exami	ıçı	1806 Jarvis Avenue	9		Oxon Hi			1	ince Ge	
	Funeral Director		379-32-2000	7.4 -670	(In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit Month, De 07/22/	1931	9. Birth Co	nplace (State or Foreign untry) Germany
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation					10d. Inside City Limits
	Maryl 1 sho	tor	Maryland Prince Ge		Oxon I						1 ☐ Yes 🏋 🗓 No
	th the or 288	irec	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?
	ath wi	ral	1806 Jarvis Avenu	ıe			745			rmany	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23s or 28s-1 show or other traumatic evant, the Medical Evantinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2፟፟XXIo	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of workii	na	16b. Ki	ind of Business/l	ndustry
121	within ane. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) Hairdres:			Bea	auty Sho	D
	filed hygie	e Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle			r
<u>a</u> n	Mental Mental rkad o	To Be	Max Alfred Schaff	ert					Ros	a Grune	r
Maryland	and 2 should be filed withir ealth and Mental Hygiene. n 27 is markad othar than iar traumatic evant, it e M		19a. Informant's Name/Relationship (Ty Angela Z. Woodward		19b. Maili 1465	ng Address (Street and S. Highv:	iew Lane	/Route Numb #303 A	er, City o Llexa	r Town, State, Z ndria,	ip Code) VA 22311
Baltimore,	of Head		20a. Method of Disposition 1 ☐ Burial 2 KIX remation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)		ate	20c. Lo	ocation - City or	Town, State
ij	Pages tment of t tant: If it		`4 □Donation 5 □ Other (Specify)		Kalas Cre	-	10/02/		_	-	Maryland
Bal	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra <u>once</u> .		21. Signature of Funeral Service License		6.1	2. Name and Address	eorge P.	Kalas	Fune	ral Hom	e PA
			23a. Parti Enter the disease, or compl shock, or heart failure. List only or	ications that caused th		60 Oxon H er the mode of dying,				Marylan	Approximate
	Physician		Immediate Cause (Final disease or condition	ne cause on each line.	++	• 0	gwa				Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as a	consequence of):	COUNT	GW C				
В	Examiner	_	Sequentially list conditions,	b. ————————————————————————————————————	consequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a t	consequence or).						
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be ex physician the buria	dlcal		d							
9	certific	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					20d Date of dall	
Box	he death certifics the attending pt ched for use as t	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at tir		Ectopic pregnancy Other (specify)			1	23d. Date of deliments Month	Day Year
P.0	at the by the	hys	9 Unknown	9L Unknown				1			
	 requires that the death been signed by the atte should be detached for 		Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause given	in Part I.			_	the cause of death?
orc	requi	eted					· · · · · · · · · · · · · · · · · · ·	-	Yes 2		. *
Records,	The faw ate has I page 2 s	Completed						24a. Was auto perfo		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
tal		a)	25. Was case referred to medical				26. Place of Death	1 Yes	2 No	1 🗆 Yes	2 No
Į (hysici nis ce I direc	To B	examiner? 1 ☐ Yes 2XXIvo	lospital:	2 ER/Outpatier	Othor				6 Other (Spec	ify)
Division of Vital	Attanding Physician: r death. actor: After this certific. by the funeral director,	on:	27. Manner of Death 1 X ¥atural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time o Injury	Work?		8d. Describe	how injur	y occurred	
isio	Attandii death. ctor: A y the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	/ - At home, farm, sti		es 2 No	98f Location /	Street an	d Number or Ru	ral Route Number.
ο	al or A s after I Dira	Certification:	4 Homicide determined	building, etc.	(Specify)	oot, radiory, ornog		City or To			arriodis ramber,
	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	Medical 0	29a. Certifier (Check only one) 2 Medicel Exemi	sicien: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	and due to the ad at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	2		29c. License r	A 4 -	14.	29d. Dat	e signed (Month	Day, Year)
	. 4.		Kser	mens a		201010	434 U	194	- 1	0/1/0	4
	10		30. Name and address of person who co Robert J. Meister				r Suita	170	\r1 -	oten V	A 22205
	Sta	ate	04 D : 01 1 04 -0 D - W 1		2.			170, F	71 T T U	iglon, V	A 222U3
	Regist		OCT 0 6 20	04 Zen	va B						
DH	MH 17 Rev 1/2	2001			10	spale	1				
					ORIGINA	AL .					

			1 - State Registrar	tate of Ma			tment of H		Mental Hy	giene	04	3157	17
			Decedent's Name (First, Middle, Last)						2. Date of D		Year	3. Time of Dea	ath
	Physici /Medi		J. Russell Butcher						Sept	21 4c. Count		5:351	РМ
	Examir	ner	4a. Fecility Name (If not institution, give street	,			lb. City, Town, or		ath				
	Funeral	,	16505 Virginia Ave 5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	iday)	Williams If Under 1 Year Months Days	Tr Under 24 H Hours Mi		rth PV Year)	shine 9. Birthi	J Lon place (State or Fo ntry)	oreign
<i>₽</i>	Director		180-05 3057	2□ F	90 Y	rs.	vioritis Days	Hours Wi		7 1914		nsylvani	ia
3	anyland		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Li	imits
a	vith the Maryla or 28e-f shov	ctor	Maryland Washington	n	Will	iams	port					1 ☐ Yes 2 💆	XNo
10	with th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
3	TIS 23a	Funeral	16505 Virginia Ave. 11. Marital Status	Was Decedent E	ever in U.S.	13. Wa	21795 as Decedent of Hi		(Specify Yes or N	U.S.A	ce - Ameri	can Indian,	
(Q)	rs after death v ', or items 23a	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 X N If Yes, Give	lo		es, specify Cubai Yes 2∭ No		(Specify Yes or Ne erto Rican, etc.)		ck, White,		
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f ahow the Medical Examinat must be notified	d by	3 X Widowed 4 □Divorced	Year or Dates:	100 5						か Whi		
215	n na Ne Lic	plete	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	mpleted)	(Give kir life. DO	nt's Usual Occupa nd o <i>f work</i> done o NOT use retired,	ltion Juring most of w	rorking	16b, Kind of B	usiness/In	dustry	
	T 70 2 2	Completed		College (1-4or 5	+)	Min	ister			Churc			
and	B la b	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sumar	ne)		
ary	# B E E	입	Harvey J. Rutcher 19a. Informant's Name/Relationship (Type,	Print)	19b. I	Mailing /	Address (Street a		Russell Rural Route Numb	er, City or Town,	, State, Zit	Code)	
) X	9 E M =		Janice B. Sedaka (Daughtei			Whitley					yland 20	814
Ore			20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Remo		20b. Place of E	Dispositi , cremat	on (Name of lory or other place)	Date	20c. Location	- City or To	wn, State	- 27
@ #	permit. Pages Department of Important: If is any Injury or o		*4 □Donation 5 □ Other (Specify) 21. Signature of F neral Service Licensee	0.	Smiths				t. 23, 0				
Ba	permit. Departm Importa any Inju		Hanul O. Fr	lules	N.	133	31 Easte	rn Blvd	ouglas A ,N. Hage	rstown,	Fune: Mary	ral Home land 217	! !42
			23a. Part\ Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final	ons that caused ause on each lin	the death. Do no	t enter t	Λ		,			Approximate Interval Between Onset and Deatl	n th
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of	TC.	Walce	DVW	ular o	CTEGS	e	Clus	
	Examiner		Sequentially list conditions b			,					(
	pe per lisit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence of):							
2.	be executed sician and burial-transit	Examiner	that initiated events c	Due to (or as a	consequence of):							
che 8760	certificate be executed Iding physician and Ise as the burial-transit		d										
X 68	ath certifica ttending ph or use as th	Med	IF FEMALE:							8			
Boy	attend for us	Physician/Medical	in the past 12 months?	lf yes, outcome o 1□Live birth = 2 4□Pregnant at t	2 Fetal death		topic pregnancy ther (specify)				ite of delive onth	ory Day Year	. =
0.	t the de by the tached	hysi		9□ Unknown									
S, F	es that igned be de		Part II. Other significant conditions contribu	uting to death bu	t not resulting in t	the unde	orlying cause give	n in Part I.	_	_		ne cause of death	
Se	w requir	eted	parpria						1 🗆			ably 4 Unkno	
AS Rec	The law ate has i page 2 s	Completed by							24a. Was auto perfo	osy ormed?	prior to cor death?	psy findings availa mpletion of cause	able of
d ia		0	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only o		1 🗆 Yes	2 No	
\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	ding Physician. After this certific funeral director.	To B	examiner? 1 Tes 2 No Hosp	1 🗀 Inpatier		_	3□ DOA Othe	4 Nursing	Home 5 ☐ Resi	dence 6 Oth	ner (Specif	r)	
7)	Attending Physician: r death. totor: After this certific by the funeral director.	ion:	1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day	Year) 28b. Tir Inje		28c. Injury Work	at ? es 2 □ No	28d. Describe	how injury occur	red		
Division	Attend ir death ector: / by the f	Certification:	a Could not be	8e. Place of Injur	ry - At home, farm	n, street			28f. Location (Street and Numb	per or Rura	I Route Number,	
اِم	pitel or Att ours after d ieral Direct		4 Hornicide	building, etc.					City or To				
	Hos Hos Fur tely	edical	29a. Certifier (Check only one) Certifying Physicis	n: To the best of On the basis of and manner stat	examination and/	death od or inves	ccurred at the time tigation, in my op	e, date and place nion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)	
	To the within 2 To the complex	Me	29b. Signature and title of cepture				29c. License	number	36	29d. Date signed	d (Month,	Day, Year)	
	13		Make		- th (th		D	2050	16	spren	50	24,00	94
2	3H-13		30. Jam and dress person who pl	eted cause of de	atn (Item 23a) (T	ype, Hin	Apine	Had	ips/ou	-MD	21	742	
	Sta		31. Date filed (Month, Day, Year) SEP 2 3 2004	32. Registra	r's Signature	1		V					
	Registr	ar	OLI & 3 2004	Allele		DOR	Mer.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician ptember 19 Marion Boppe 2604 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 31,1917 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. 214-09-9833 86 Director Maryland Usual Residence of Decedent death with the Maryland nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan attended of Health and Mental Hygiene. orderin: If item 27 is marked other than "natural; or Items 23e or 28e-1 show injury or other traumatic event, Itte Meutical Exempleat or usal be retilified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo MD Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Sunbrook Lane 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Purchasing Agent Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William A. Boppe Edith Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Boppe/Wife 76 Sunbrook Lane Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 9/22/2004 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bronary **Physician** irle 20 /Medical Due to (or as a consequen of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. East of confing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 PNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 20-04 5H-0 pleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day 23, Month **Physician** September 2004 1:40 A. Carl Lyle Bock /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Lanham Magnolia Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Dec. 1, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☑ M 2 ☐ F Yrs. 88 Maryland 216-44-7083 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatih and Mental Hygiene. Internate in them 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location or than "natural", or items 23s or 28s-f show the Wedical Examinar must be nutilised at 1 ☑ Yes 2 ☐ No Landover Hills Prince Georges Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4213 72nd Avenue 20784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Gov't. Personnel security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Car1 Bock Ada Rader 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher E. Bock - Son 12507 Saber Lane, Bowie, Md. 20715 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 09-23-04 Alexandria, VA. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21 Signeture of Funeral Service Licensee Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction minutes **Physician** /Medical Due to (or as a consequence of): **Examiner** Diffuse coronary atherosclerosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 XNo 3 Probably 4 Unknown Hypertension, anemia, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case reterred to medical examiner? Hospital: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DDA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 XNatural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Versteig 200 D24720 Sept. 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Rustagi MD, 6132 Landover Rd., Cheverly, Md. 20785 32. Registrar's Sign SEP 2 3 ZUU 4 State Registrar

John Bogardus 04-06024 MAN

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۰	j	· p	Decedent's Name (First, Middle,	Last)								2. Date of De	ath		V	3. Time of	Death
	sician edical		JOHN BRUCE BOGA	ARDI	JS, JR.							Septemb	er I	8, 2	200°4	0746	Ам
	miner	4a.	Facility Name (If not institution,	•					_	Location of	of Death			,	of Death		
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Fune Direct			Social Security Number 12–98–0972	3. Sex 1 ∑ ∫	M 2 F		. last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bill (Month, Da	ay, Year)	(1)	Coun		
	.or	1-	ual Residence of Decedent			40						Feb. 28	3, 19	04	wasn	ington	i, DC
yland how		10	a. State 10b. County			10c. C	ity, Town or Lo	cation							11	Od. Inside Ci	ty Limits
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or 28	Director	100	a. Street and Number					10f. Zip					•		hat Coun	try?	
ath w	ie	5	305 Riverdale E						20737				U.S				
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28e-f show or other tranmatic event, the Medical Experiment the profiled at	hv Funerai	11.	Marital Status 1 Never Married 2 Marrie 3 Widowed 4 X Divorced	_	 Was Deced Armed Force Yes 2 Yes, Give Year or Date 	es? ∭No				ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	D-	Blac	e - Americ k, White, d : Whi	etc.	
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. Box 68760, death certificate be executed eathending physician and of for use as the burial-transit	Physician/Me	23	FEMALE: b. Was decedent pregnant	23	c. If yes, outco	me of pregn h 2 □ Feta		Ectopic pr	egnancy				2		of deliver		
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Divi To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Z		b. Signature and title of certifier	ì	Λ			290	. License	number			29d. Date	e signed	(Month, E	ay, Year)	
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	1	30	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
r	Physicia /Medic		Lorraine Lillian Blacker			er 20, 2004 3:00 a M
).	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		*	2-B Westway Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Greenbelt If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince George's 9. Birthplace (State or Foreign
П	Funeral Director	ž –	5. Social Security Number 319-16-4836 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	June 9,	Country) 1919 Illinois
Н	B		Usual Residence of Decedent			
	show	_	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	88-f	Directo	Maryland Prince George's Greenbelt	10f. Zip Code	100	. Citizen of What Country?
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	ns 23	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel', or Items 23c or 28e-f show any injury or other treumetic event, it a Marical Examination in any injury or other treumetic event, it is Marical Examination and once.	by Fun	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
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Baltimore, Maryland	permit. Departi Import any inj		21. Signature of Europeal Service Licensee	22. Name and Address of Facility Ga 4739 Baltimore Av		eral Home, P.A. ttsville, MD 20781
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
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Вох	eath certific attending p	Physician/Me		□Ectopic pregnancy		23d. Date of delivery Month Day Year
0.	the dea y the a	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		
0	that ed b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ds,	es gu	d by			1 X Yes	2 No 3 Probably 4 Unknown
Vital Records,	> 0 0	ompleted			24a. Was an	24b. Were autopsy findings available
Re	9 4 9				autopsy performe 1 ☐ Yes 2 🗹	orior to completion of cause of death? No 1 □ Yes 2 □ No
ita		3e C	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
of V	tending Physicien: leath. tor: After this certific the funeral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati			ce 6 Other (Specify)
		on:	27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Wark?	28d. Describe how	injury occurred
isio	Attending r death. Sector: After on the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Stree	et and Number or Rural Route Number,
Division	or Min t	Certification:	4 Homicide determined building, etc. (Specify)	treet, ractory, onice	City or Town, S	State)
	Hos Turk Bly	edical C	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, de. 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the Hos within 24 ho To the Fun completely	Me	29b. Signative and title of certifier)	29c. License number	29d	. Date signed (Month, Day, Year)
	FSFO		M. Odnice M.D.	D16378	Se	eptember 21, 2004
	e (in		30. Name and address of person who completed cause of death (Item 23a) (Type		31.35	
	1 (0)			Avenue, Suite 705	, Chevy C	Chase, MD 20815
0	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 2 2004	ode .		

			FOR	artment of Health and Mental ertificate of Death	Hyglene Reg. No. 004 3 582
ī	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Month	of Death 3. Time of Death
	/Medic Examin	al	GRACE MARIE BROSCHART 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park	EMBER 17, 2004 1:25A. M 4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 224-32-5383 0. Sex 1 M 2 F 82 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Feb.	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland e-f show	ctor	10a. State 10b. County 10c. City, Town or L Maryland Prince George's Adelphi	ocation	10d. Inside City Limits 1 ☐ Yes 🔏 ☐ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 2615 Cool Spring Road	10f. Zip Code 20783	10g. Citizen of What Country? United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show appropriate Items 23a or 28a-f show any injury or other traumette event, the Medical Exam per multiple at once.	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc. Specify: Caucasian
21215-0036	within 72 ho lene. then "natur the wedical	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) stered Nurse	16b. Kind of Business/Industry Medical
Maryland 2	uld be filed Jental Hygirked other	To Be C	17. Father's Name (First, Middle, Last)	chart Nellie (First, Mi	iddle, Maiden Sumame) Leahy
, Mary	and 2 sho saith and A n 27 is ma er traume			ing Address (Street and Number or Rural Route N 5 Cool Spring Road Adel	
Baltimore,	Pages 1 ment of He ant: If itan iury or oth		'4 □ Donation 5 □ Other (Specify) George Wa	ashington Cem. 9/17/200	- , -
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee Noneld V. Buzerwatt	2. Name and Address of Facility Donald V. Borgwardt Fund 100 Powder Mill Road Be	eral Home, P.A. ltsville, Maryland 20705
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each the limited that cause (Final disease or condition resulting in death) a	Obstructury Alek	Onset and Death
8760,	the death certificate be executed the attending physician and ched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Chromital part	elixar
O. Box 6	ath certifi	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	wrequires that the de been signed by the a should be detached to	by	Part II. Other significant conditions contributing to death but not resulting in the	, <u></u>	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown
l Records,	- E C	Completed	- areurism		Was an autopsy findings available prior to completion of cause of death? es 20 No 1 ☐ Yes 2 ☐ No
of Vita	Physician this certifi ral director	: To Be	25. Was case referred to medical examiner? 1 Yes 2No		nnty ofie) Residence 6 □Other (Specify) ribe how injury occurred
Division	To the Hospital or Attending Physician. The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined (Month, Day Year) Injury 28e. Place of Injury - At home, farm, si building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	ion (Street and Number or Rural Route Number, r Town, State)
346	the Hospitel or in 24 hours afte the Funeral Dir ppletely filled in	Medical C	29a. Certifier (Check only one) **Description on the Dest of my Knowledge, deal of the Dest of the Dest of my Knowledge, deal of the Dest of the De	ovestigation, in my opinion, death occurred at the ti	ime, date and place, and due to the cause(s)
Ax 2	To the within to the comple	Z	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
9	- '			Print) enue Takoma Park, Maryla	and 209/12
	Sta Regista		31. Date filed (Month, Day, Year) SEP 2 1 2004 32. Registrar's Signature	Sparks	

			For State Registrar	State of Mary		artment of rtificate of		nd Mental Hy	giene	14 3 5	83
Н	Physic	ian	Decedent's Name (First, Middle, Las.					2. Date of De Month	eath Day	3. Time of	f Death
	/Medi	cal	Mary Elizabeth B						per 20,	7.40	а м
	Exami	ner	4a. Facility Name (If not institution, give				or Location of [Death	4c. County	,	
-	Funeral		Mariner Health- I 5. Social Security Number 6. Se		yrs. last birthday)	Bethe		Hrs. 8. Date of Bi	rth	gomery	or Foreign
L	Funeral Director			☐M 2131F	69 Yrs.	Months Days		Min. (Month, Da	ay, Year) 2, 1935	9. Birthplace (State of Country) Maryland	n roreign
	nyland how		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside Ci	ity Limits
	e Ma	cto	Maryland Montgom	nery	Kensing	ton				1 ☐ Yes	2 X No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	s 23a	- a	<u>-</u>	enue		2089			USA		
	lterne	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?		Was Decedent of f Yes, specify Cu	Hispanic Origin ban, Mexican, P	n? (Specify Yes or No Puerto Rican, etc.)		ce - American Indian, ck, White, etc.	
38	Irs af	by F	3₺ Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specif	y:White	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show displ Examinet must be to diffed at	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occu	upation		16b. Kind of B	usiness/Industry	
218	thin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retir	e during most of ed)	f working		,	
7	ygien yer th	Completed	12		Hom	emaker			Own H	ome	
Maryland	be fill ntal H nd oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Suman	ne)	
3	d Mer nerke	P	Porter William F					Dorothy			
Mai	d 2 st th and 7 la r traur		19a. Informant's Name/Relationship (T) Wayne P. Brickhous					or Rural Route Numb Nay, Olney			
á,	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia markad other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffical at once.		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of				City or Town, State	
<u>o</u> n	ages ant of tr: IT is		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Mount Ca	natory or other pla rme1	ace) Se	eptember 24.			
altimore,	nit. Partme ortan injur		21. Signatur of juneral Service Licens		Cemete		ress of Facility	2004	Sunshin	e, Maryland	<u> </u>
ñ	Par Par Par Par Par Par Par Par Par Par		1 inches	L slo	F'r 50	ancis J. O Univer	Collir csitv Bl	ns Funeral	. Home I Silver	nc. Spring, MD	2090
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events	a. Lung Canc Due to (or as a cor	er nsequence of):	er the mode or dy	ing, such as car	diac or respiratory a	rrest,	Approximation Approximation Between Be	ween
P.O. Box 68760,	that the death certificate ba executed ed by the attending physician and detachad for use as the burial-transit	Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖾 No 9 □ Unknown	Due to (or as a cord. 3c. If yes, outcome of print During birth 2 Degrand at time 9 Unknown	egnancy Fetal death 3	Ectopic pregnanc Other (specify) _	cy		23d. Dat	e of delivery nth Day Y	/ear
	quires tha in signed uld be del	by	Part II. Other significant conditions col	ntributing to death but not	resulting in the un	iderlying cause gr	ven in Part I.			ribute to the cause of de	
al Records,	: The law requires that the cate has been signed by th page 2 should be detacha	Completed						24a. Was — autop perfo 1 Yes	rmed? p	Vere autopsy findings a prior to completion of ca leath? ☐ Yes 2☐ No	ivailable luse of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		04		Death (Check only o			
ō	Phys this ral di	tlon: To	1 ☐ Yes 2X No ☐ 27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Inju	4 LX Nursin	ng Home 5 Aesid 28d. Describe h	dence 6 Other		
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, streecify)			28f. Location (S City or Ton	Street and Number vn, State)	er or Rural Route Numb	oer,
	To the Hospital or Atwithin 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in my	opinion, death o	ace, and due to the occurred at the time,	cause(s) and mai date and place, a	nner as stated. Ind due to the cause(s)	
	To with	Σ	29b. Signature and title of certifier	p-	11		se number			(Month, Day, Year)	
	10		· mor	1	D	DO	057	124	9/20	104	
	Sta Registr		30. Name and address of person who comes address of person who comes and address of person who	ruong Bao	M.D. 1	- 160		lark Torr	., Gorma	ntown, FD	2087.4

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Theodora /Medical Lo1a Brandy September 16, 2004 2:40 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 € F Director Yrs. 579 14 0151 Sept. 21,1918 Washington,D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any jury or cother traumatic event, the Medical Exercitive must be inclined at once. 1 Yes 2 No Director Maryland | Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3921 Mount Olney Lane Funeral 20832 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ♣ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Department Manager US Government 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame Be Christo Brandy Victoria Garabaldi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 Mount Olney Lane Olney, Maryland Mary Sanchez / Daughter 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 9/20/2004 Washington, D.C. 22. Name and Address of Facility Hines Rinaldi Funeral Home 20904 21. Signature of Funeral Syrvi 11800 New Hampshire Avenue Silver Spring, MD 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) End Stage Renal Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The taw requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2X No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 **X**Other (Specify) **Hospice** Hospital: 1 ☐ Yes 🌋 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, Maryland Charles Harrison, M.D. 31. Date filed (Month, Day, Year) **SEP 21** 2004 32. Registrar's Signature State Darks Registrar

			1 - For Stata Registrar		larylan		rtmen tificate	t of H	ealth a		lental Hyg	_	1		85
	Physic /Medi		1. Decedent's Name (First, Middle, L Jean Mackenz	,							2. Date of Deat Month Sep.	Day 20, 21	Year	3. Time of 8 : 1 (М
	Examir		4a. Facility Name (If not institution, gi Genesis Elde:)				Location o	of Death	_	4c. County of	of Death	runde	
	Funeral Director		104-18-8958	Sex 7.A 1 □ M 2 🔀 F	ge (In yrs. I 82	ast birthday) Yrs.	If Under Months		If Under		8. Date of Birth (Month, Day, Sep. 15	Year)		lace (State of try) NY	
	Maryland a-f ahow ilied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	10c. City	, Town or Lo	cation evern	a Pa	rk				10	0d. Inside Ci	•
	with the 3a or 28a	i Direc	10e. Street and Number 16 Windward Driv	7e			10f. Zip		146		10	g. Citizen of W		try?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event. Its Medical Examinar must be notified at 000ce.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Amed Forces 1 Tes 2 St If Yes, Give Year or Dates:	?	li li	Vas Deced Yes, spec	ent of His		gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14. Race	, White, e		
21215-0036	vithin 72 h ne. han "natu e Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	16a. Deced (Give life. L	ent's Usua kind of wor OO NOT us	k done di	uring most	of worki	ing	6b. Kind of Bus	iness/Ind	lustry	
Maryland 2	should be filed wond Mental Hygie i marked other tumatic event.	To Be Co	12 17. Father's Name (First, Middle, Las Gardner Earl Mac]			r's Name	(First, Middle, N				
	1 and 2 shou Health and N em 27 is mai		19a. Informant's Name/Relationship Brad Bell/Son	(Туре, Print)		16 Wi	.ndwa:	rd Di	cive,		A Route Number, Terna Par		tate, Zip	_	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Structure 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special Content of the Cont			ace of Dispos metery, crem Vetera	ns Ce	emete	ery '	Sep.	23,	oc. Location - C rownsvi	lle,	MD	
Ball	permit Depart Impor any in		21. Signature of June al Service Lice	an							A. Sever y, Sever	HG FOLK	Fun MD	eral H	Home
30,	And the burial-transit	l Examiner	23a. Part. Enter the disease, or consher, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s a conseque	o Vas		2	, such as d	1	L'SEG			Approximate Interval Beh Onset and D	ween
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnapt in the past 12 months? 1 □ Yes 2 □ Vo 9 □ Unknown	d	2 Fetal	death 3□	Ectopic pre Other (spe					23d. Date Monti			'ear
<u> </u>	w requires that been signed b should be deta	by	Part II. Other significant conditions		out not resul	ting in the un	derlying ca	use giver	in Part I.			cco use contrib	ute to the		eath?
Vital Records,		e Completed	25. Was case referred to medical						00 PI		24a. Was an autopsy perform	ed? de:	ore autops or to com ath?] Yes 2	sy findings a pletion of ca	ivaliable luse of
Division of Vi	Attending Physician: or death. ector: After this certifici by the funeral director,	To B	examiner? 1 Yes 2 1 Yo 27. Manner of Death 1 Datural 5 Pending 2 Accident investigatio	Hospital: 1 Inpation 28a. Date of Inju (Month, Date)		R/Outpatient 28b. Time of Injury		C. Injury a	410 Nur	sing Hom	(Check only one) ne 5 ☐ Residen 8d. Describe how	ce 6 □Other			
DIVIS	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	286. Place of In	ury - At hon c. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (Stre City or Town,	et and Number State)	or Rural i	Route Numb	ner,
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Property one) 2 Medical Example (Check only one)	nysicien: To the best niner: On the basis o and manner st	r examinatio	ledge, death on and/or inve	occurred at estigation, i	t the time n my opir	, date and nion, death	piace, a occurre	nd due to the cau d at the time, date	se(s) and mann a and place, and	er as stai d due to t	ted. he cause(s)	
	To T To 1	Σ	29b. Signature and title of certifier	11	~	mi) 29c.	License	oumber 7	72	5	Date signed (Month, Da	ay, Year) 200	14
			30. Name and address of person who	dinger &	Seath (Item 2	Vere	rint)	#	Wy	Mi	5 llers	ille,	MI	011	08
0	Sta Registr		31. Date filed (Month, Day, Year)	32. Readin	ar's Signatu	ire	hair	20	U						

State of Maryland / Department of Health and Mental Hygiene

	State of Ma	Certificate of Death	Reg. No? 0 0 4 3 1 5 8 6
Physician	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Day Year 3. Time of Death
/Medical	LANDONIA JOHNSON BUTLER	4b. City, Town, or	Sept. 20, 2004 8:13 am
Examiner	4a Fecility Neme (If not institution, give street end number)		
	Civista Medical Center 5. Social Security Number 6. Sex 7. Age	r LaPlata (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	Charles 8. Date of Birth 9. Birthplece (State or Foreign
Funeral Director		66 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer) DHCHMBER 22,1937 9. Birthplece (State or Foreign SOUTH CAROLINA
yland		10c. City, Town or Location	10d. Inside City Limits
the Maryla rettred in rector	MARYLAND CHARLES	LA PLATA	1 Ma Yes 2 □ No
death with the Maryland rms 23s or 28s-f show rms the notified at mast be notified at meral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ath w	10860 HOPEWELL PLACE	20646	UNITED STATES
ur, or its	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Examed Forces? 1 Yes, Give Year or Dates:	If Yes, specify Cuban, Mexicen, Puert 1 □ Yes 2 No Specify:	Specify: BLACK
15-115-115-115-115-115-115-115-115-115-	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking 16b. Kind of Business/Industry
1 21215-00 led within 72 hou bygiene. Par than "naturant, to medical et. to medical et. to medical et.	Elementery/Secondery (0-12) College (1-4or 5+	BUS DRIVER	TRANSPORTATION
land 21. Iland 21. Iland 21. Ilabe filed wit inente Hygiene ted other tru ic event, tre o Be Corr	17. Father's Neme (First, Middle, Lest)		ne (First, Middle, Maiden Surname)
yland yland yland buld be fil Mentel H mrked off mfic ever	WILLIE L. SIRAIN	MARY E. I	DOOD STRAIN
any should be market turned in the state of	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	urel Route Number, City or Town, State, Zip Code)
Dre, Maryland 2 Dre, Maryland 2 so 1 and 2 should be filed to Health and Mentel Hygins filem 27 is marked other rother traumatic event, at	SANDRA R. HARTSFIELD / DAUGHTER	P.O. BOX 1871 LA PLATA, MAR	XYIAND 20646
4 = 5 = 0	20a. Method of Disposition 1	20b. Place of Disposition (Name of cemetery, cremetory or other place) ST. CATHERINE'S CHIRCH CEMETERY	Date 20c. Location - City or Town, State 9/25/2004 MC CONCHIE, MARYLAND
Baltim permit. Pe Department Important: any injury once.	21. Smature of Puneral Service Licent LYDIA C. THORNION JOHNSON MO058		INDIAN HEAD, MARYLAND 20640
Physician Medical Examiner	23a. Pert1. Enter the diseese, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	the deeth. Do not enter the mode of dying, such as cardiad as a consequence of):	c or respiratory arrest, Approximate Interval Between Onset and Death
In sit	- b		İ
68760, ificate be executed g physician and as the buriel-trensit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	tue to (or as a consequence of).	
	resulting in death) Last	ue to (or as a consequence of):	
I Records, P.O. Box The law requires that the deeth cert ate has been signed by the ettendin page 2 should be deteched for use Completed by Physiclan/N	Part II. Other eignificant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
rds, I			24a. Was an autopsy 24b. Were autopsy findings
The law require tage has been signage 2 should I Completed I			performed? available prior to completion of cause of deeth?
Vital Fidelin: The certificate rector, pag	25. Wes case referred to medical	26 Place of Dec	1 Yes 2 No
of Vita hysician: his certific al director,	examiner? 1 Yes 2 No Hospitel: 1 The patient	Othor	lome 5 ☐ Residence 6 ☐ Other (Specify)
Ing Ph. After th funeral	27. Manner of Death 1 Naturel 5 Pending (Month, Day) 2 Accident investigation		28d. Describe how injury occurred
Division C Division C 6 Hospital or Attending PI 7.4 hours eiter death. 6 Funeral Director: After ti 9lelely filled in by the funeral edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, street, factory, office (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	my knowledge, death occurred at the time, date end place exeminetion and/or investigation, in my opinion, death occued.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To # COMING	29b. Signature end title of certifier	29c. License number D-21031	29d. Date signed (Month, Day, Yeer)
iA5	30. Name end eddress of person who completed cause of dea Michael Leatherwood, MD). 12070 Old Line Cente	er, Waldor, MD 20602
State Registrar	31. Dete filed (Month, Pay Year) 2 2004 32. Registrar	's Signature Anada	

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	Marylar		artment <i>rtificate</i>			lental Hygi	ene	31587
	Physici /Medic		Decedent's Name (First, Middle	Gary I	Blaine 1	Baer	-			2. Date of Death Month Septem	Day Year ber 24, 2004	3. Time of Death 7:45 A, M
	Examir		4a. Facility Name (If not institution	n, give street and number IU Castle H	ΪΊΙ		4b. City, To		ocation of Death Lonace	oning	4c. County of Deat	legany
	Funeral Director		5. Social Security Number 219-44-0001 Usual Residence of Decedent	6. Sex, 10X M 2□F	Age (In yrs. 60	last birthday) Yrs.	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) April 09,		hplace (State or Foreign untry) Maryland
	Maryland -f show	tor	10a State 10b County	Baltimore	10c. Cit	ty, Town or Lo	ocation	I	Baltimore			10d. Inside City Limits 1 ∰Yes 2 □ No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 6511	Danville Avenu	e		10f. Zip C	ode	21224	104	g. Citizen of What Co	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural; or items 23a or 28a-f show important: If tien 27 is marked other than "natural; or other traumatic event, I'm Medical Example must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🏋 Divorced	If VAS GIVA	s?] No		Was Decede If Yes, specif		panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur the Wedical	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-40	r 5+)	16a. Deced (Give life.	dent's Usual kind of work DO NOT use	done dui retired)	on ing most of work Mechanic	ing 16	Sb. Kind of Business/	Industry pment
yland 2	should be fited on the marked other imarked other immatic event, It	To Be C	17. Father's Name (<i>First, Middl</i> e,	Last) Richard Elmer B	aer Sr.			1	8. Mother's Nam	e (First, Middle, Ma Janet E	aiden Sumame) laine Kerling	
, Mar	and 2 sho lealth and I m 27 Is ma her traums		19a. Informant's Name/Relations Gary F.	hip (Type, Print) Bear-son				8248 C			Dity or Town, State, Z Maryland 21222	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	pecify)	_ 0	Place of Dispo cemetery, cren Rocky Gar	Veterans	er place) s Ceme	tery	Pate 20 September 27, 2004	Flintstone,	
Ba	Dermi Depa Impo any ii		21. Signature of Funeral Service	2	and the and another	Ei		1cKenz	ie Funeral H			oning,Md.21539
3/60,	Cate be executed // Medical Examiner the burial-transit the burial-transit cate of the burial-transit	dical Examiner	23a. Part Enter the disease of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	is a conseq	Uence of):			-	ing Dis	1	Approximate Interval Between Onset and Death
ň	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Feta	Ideath 3□	Ectopic preg Other (spec				23d. Date of deliv	∕ery Day Year
rds, P	signed be de	by	Part II. Other significant condition	ons contributing to death	but not res	ulting in the ur	nderlying cau	se given i	in Part I.		cco use contribute to	the cause of death?
_	10 LL	Completed								24a. Was an autopsy performer	prior to co	opsy findings available ompletion of cause of
VISION OF	potal or Attending Physician: ours after death. seral Director: After this certifical filled in by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investic 2 Accident 6 Could referred 4 Homicide determ	Hospital: 1 Inpat 28a. Date of In (Month, D) gation not be ined 28e. Place of Ir	jury ay Year)	ER/Outpatient 28b. Time of Injury ome, farm, stre	28c	Other: Injury at Work? 1 Yes	4 ☐ Nursing Ho	28d. Describe how	et and Number or Rur	V.ESINCALE.
	Lo the Hospital or within 24 hours afte To the Funeral Dir. completely filled in the Funeral Dir.	Medical C	29a. Certifier (Check only one) 1 ☑ Certifyin 2 ☐ Medical	g Physicien: To the bes Examiner: On the basis and manner s	or examina	wledge, death tion and/or inv	estigation, in	the time, my opini	on, death occurre	ed at the time, date	and place, and due t	to the cause(s)
	7720		30. Name and address of person	& Chap	death (Item	1 23a) (Tvne F		1 -	5120		Date signed (Month,	0 -1
	Sta Registr		Thomas E 31. Date filed (Month, Day, Year) SFP 2. 7?	Chappe !	MD trar's Signa	91-	2 Se Sport	ton	Dr	Cumber	1/24/6	MD

10		1 - For 9-30-04 Registrar Amend #20b.20			rtificate			na M		g. No. () (The state of the s	3 5 8 (
Physicia /Medica Examine	al	JOHN 4a. Facility Name (If not institution, give			BUTTS 4b. City, 7	Town, or	Location of		Month SEPTEMBE	Day	Year 2004 y of Death	1:00 P
Funeral Director		JII LT JJJU A		s. last birthday) Yrs.	La If Under Months	nhai 1 Year Days	n If Under 24 Hours	Min.	8. Date of Birth (Month, Day, Mar. 19,	Princ Year) 1923		place (State or For
Sa-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		City, Town or Lo	ocation						1	0d. inside City Li 1X Yes 2 □
al', or itams 23e Examiner must	by Funeral	10e. Street and Number 9313 Lanham-Sever 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	n Rd. 12. Was Decedent Ever in Armed Forces? 1 Xes 2 196/1 Yes, Give Year or Dates 02/1	02/1943	Was Decede	0706 ent of Hi		n? (Spe Puerto	acify Yes or No- Rican, etc.)		ce - Americ ck, White,	ean Indian,
than than than than than than than than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th		16a. Dece (Give life. Labor		Occupa k done d e retired	luring most o		ng	18b. Kind of Business/Industry Mazor Masterpiec		
and Mer Is marke aumatic	To Be	Robert Butts 19a. Informant's Name/Relationship (Ty	•		Ella				s Name (First, Middle, Maiden Surname Morse or Rural Route Number, City or Town, S			Code)
0	7	Eloise King/Siste 20a. Method of Disposition 1 \Regular Burial 2 \Boxed Cremation 3 \Boxed F 4 \Boxed Donation 5 \Boxed Other (Specify)		2813 Place of Dispo cemetery, crei antico ryland			-	_	9-04 I	oc. Location	Hills Md. 20748 c. Location - City or Town, State ciangle, Va. cheltenham, MD.	
Department Important: I any injury o		21. Signature of Funeral Service Licens 23a. Pany. Enter the disease, or compl	istell	22 M 4	Name and Iarsha 217 9	Addres 11's th	s of Facility Fune L. N.	ral W.	Home, I Washing	nc. ton, D		
nysician Medical xaminer s the prival-lausit	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):								Interval Betwee
ed by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pre						te of delive	ry Day Yeal
be o	2	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying car	use give	n in Part J.					e cause of death
ificate has	e Completed	25. Was case referred to medical					26 Place of	f Doath	24a. Was an autopsy perform 1 Yes 2	ed?	prior to con death?	osy findings aval npletion of causi 2 No
this aldi	ation: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury Work	r: 4 🗆 Nursi	ing Hom	ne 5 K Resider	ice 6 Oth)
in in in	ai Certification:	3 Suicide 4 Homicide 4 Certifier 1 Certifying Physics	28e. Place of Injury - At building, etc. (Spec	nowledge, death	occurred at	t the time	e. date and	place, a	28f. Location (Stre City or Town,	State)	inner as sta	ated
n 24 h ha Fui pletely	Medical	(Check only 2 Medical Exemirone) 29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	action and/or inv	estigation, i	n my op License	number	occurre	d at the time, dat	e and place, Date signer	and due to	the cause(s) Day, Year)
IUA	e	30. Name and address of person who co ANTHONY ARCENAS, M 31. Date filed (Month, Day, Year)	· ·	O IRVIN		EET	NW, WA	ASHI	NGTON, DO	20422	2/688	

		1 - For State of Maryland / Department of Health and Mental Hygiene **Certificate of Death** **Reg: No.										
			Decedent's Name (First, Middle, La	st)	~			2. Date of Death				
	Physici		Kathleen	Susan	Re	ard		Month	r 27, 200			
	/Medio Examin		4a. Facility Name (If not institution, giv				r Location of Death	septembe	4c. County of De	<u> </u>		
	Exami	ier	6713 Olde Mill Co	·		Derwoo			Montgom			
	Europal		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year	1	8. Date of Birth	9 B	irthplace (State or Foreign		
	Funeral Director			☐ M 2反F	43 Yrs.	Months Days	Hours Min.	(Month, Day, York, 1 , 1	rear) (nnsylvania		
6			Usual Residence of Decedent			L	9	CL. 1, 1	. 500 1 6	unsylvania		
	yland now		10a. State 10b. County	11	Oc. City, Town or Lo	cation				10d. Inside City Limits		
	Mar 9-f sl	to	MD Mor	ntgomery		Derwo	od			1 ☐ Yes 21∑ No		
	h the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	Country?		
	h wit	D E	6713 Olde Mill Co	ourt			20855		USA			
	deat ms	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No-	14. Race - Ал			
9	after or Ite	by Funeral	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 ☒ No				tican, etc.)	Black, Wh			
03	ref.	by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White		
5-0	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Medical Exerties frust be rollified at	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of workin	16	6b. Kind of Busines	s/Industry		
2	ithin 18	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	9				
2	filed within I Hygiene. other than	Cor		4		Accounta			Stor	e		
	0 0 0	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name		,			
× =		은	John T.	Shaw			Janet		Costello			
Maryland 21215-0036	3 8 S	0.8	19a. Informant's Name/Relationship (-	and Number or Rural					
	1 and 2 Health tem 27 i	1 3	Michael Beard/hus				11 Court,					
Baltimore,	Pages 1 nent of H int: If ite iry or oti		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	ate 20	c. Location · City o	r Town, State		
Ë			'4 □ Donation 5 □ Other (Specif		Oakland		9/30	/04 0	akland, M	laryland		
a I	permit. Departr Imports any inju		21. Signature of Funeral Service	599	22	2. Name and Addres	ss of Facility Ste	wart Fur	neral Hom	e		
ш	20599	32 S. Second St.,							Md. 2155			
П			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ent	er the mode of dyin	g, such as cardiac or	respiratory arrest	t,	Approximate Interval Between		
D	Pnysician		Immediate Cause (Final disease or condition	Overten	Cancer					Onset and Death 4 Years		
	/Medical Examiner		resulting in death)	Due to (or as a c						7 10015		
и	Cxammer		Sequentially list conditions.	b								
	po #	inei	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):							
	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c								
30,	oe ex	<u> </u>	1550king in county East	Due to (or as a co	onsequence or):							
8760,	cate b	dicai		_ d					_			
9	ertific ling p e as	Med	IF FEMALE:									
Вох	eath certifi attending I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year		
0	the a	Sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown	e of death 5□	Other (specify)			Month	Day Teat		
<u>G</u>	requires that the de een signed by the a hould be detached i	Ph)	Part II. Other significant conditions of	contributing to doub but a	at soculting in the	edechies sauss sur	on in Book I	22a Did tabar	and the analyticate	o the cause of death?		
Ś	og De	by	ratti, ottor significant conditions c	ontributing to death but is	or resulting in the di	toerlying cause give	en at Fait i.			robably 4 🛣 Unknown		
010	v requir been si should	sted						1 195	2 10 3	70Dabiy 4 20TIKITOWIT		
Records,	aw as b 2 si	ompieted						24a. Was an autopsy	prior to	utopsy findings available completion of cause of		
	Th ate pag	Co						performe 1 ☐ Yes 2 K		s 2 No		
Vital	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	I I 3-1			26. Place of Death	(Check only one)				
of	Physicia this cert al direct	ု	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 Nursing Hom		e 6 □Other (Spe	acify)		
		OD:	27. Manner of Death 1 ¬ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	ς?	3d. Describe how	injury occurred			
Sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No					
Division	or Attendate death after death Director; in by the	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, str <i>Specify)</i>	eet, factory, office	28	3f. Location (Stree City or Town, S	et and Number or A State)	tural Route Number,		
	To the Hospital or Attanwithin 24 hours after deat To the Funeral Director: completely filled in by the			<u> </u>								
	Mospital 24 hours a Funeral etely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exer	ysicien: To the best of m niner: On the basis of ex	amination and/or inv	occurred at the time occurred	ne, date and place, ar pinion, death occurred	nd due to the caus d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)		
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated		29c. License	number.	294	. Date signed (Mon	th Day Year)		
	To To con		Do D. K	VD 110				230.				
•			10 mgcs	Un MI			043934		9/28/20	U4		
	15			completed cause of death			mara MD					
			Dwight Im, M.D.	Mercy Medi 32. Registrar's		er, Balti	more, MD					
	Sta Registr		31. Date filed (Month, Day Year)	2004 32. Hearstrars		A						
				J. F. 10 20 40		BOOK D						

		1 - For State Registrar	S	tate of	Marylar	nd / Depa <i>Cei</i>	artmen rtificate			and Me		giene Reg. Ne.	004	31590	
Physici: /Medic		1. Decedent's Name (First, Mid James Robert F		У							2. Date of Dea Month Sept. 2	ath 26, 2	004 Year	3. Time of Death 4:05 A	4
Examin		4a. Facility Name (If not institut 408 Greenfield		et and num	ber)			Town, or anton	Location o	of Death		1	County of Death	1	
Funeral Director		5. Social Security Number 215–34–4345	6. Sex 1 🔼 M	2□F	7. Age (In yrs 68	. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min. J	8. Date of Birt An 31,	^h 1936	9. Birth Mary	nplace (State or Foreigi Tand	n
Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. Cour MD Garr	•			ity, Town or Lo wanton	cation							10d. Inside City Limits 1 ☐ Yes 2 🕱 No	
n with the 3a or 28a	Funeral Director	10e. Street and Number 408 Greenfield	Lane				10f. Zip		.561			-	en of What Cou JSA	untry?	
partition of the proof of the control of the control of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show empty injury or other treumatic event, the Medical Evant and the notified at an once.	þ	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Divorce	arried	Was Dece Armed For 1 Yes If Yes, Give Year or Da	2 <u> K</u>] No	4	Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec s, Puerto R	cify Yes or No ican, etc.)	S	эрвспу.	hite	
ed within 72 h ygiene. ner than "netu	Completed	(Specify only high Elementary/Secondary (0-12 12 th)	ion ompleted) College (1-	-4or 5+)	16a. Deced (Give life.	kind of wor DO NOT us	rk done di se retired) .er	uring most			16b. Kind of Business/Industry Allegany Well Drilling Co. Maiden Sumame)			
ylarını ould be fil Mental H varked oth	To Be	James Bradley							Bert	tha P	ollock			07.9	
C, Mal 1 and 2 sh Health and em 27 is m ither treum		19a. Informant's Name/Relation			20h		reenf	ield			anton,	MD	Town, State, Z. 21561 ation - City or 1		
Pages 1 tment of H tant: If ite		20a. Method of Disposition 1X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)	oval from S		cemetery, crer stlawn	matory or o Mem.	Gard	ds. S	ept 2	9,04	LaVa]	le, MD		
permit. Departr Importr eny inj		21. Signature of Fureral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 23a. Part1. Ent., the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate interval Between													
Physician are percented which are percented which in the purial transit and the purial transit are privately and the purial transit are privately and the purial transit are provided by the private are private are provided by the private are private are private are private are private are private by the private are icai Examiner	shock, or head allure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c d	Array O Du no (d	trophor as a conse	quence of):	tera	l sc	lero	sis	(ALS))		Onset and Death Onset and Death Onset and Death	S	
The COLUES, F.O. BOX 00 (00), The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c.	1 Live bi	come of pregr rth 2 🗀 Fet ant at time of wn	al death 3	Ectopic pr					23	d. Date of deliving Month	very Day Year	
r. requires that the tendent signed by should be detailed.	by	Part II. Other significant cond	itions contril	buting to de	ath but not re	sulting in the u	nderlying c	ause give	n in Part I.			obacco us		the cause of death?	1
The law require cate has been single.	Completed												24b. Were aut prior to codeath?	copsy findings available ompletion of cause of 2 No	9
OI VITATI Physicien: ' this certifica ral director, p	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No	-	pital: 1 🗀 le	npatient 2[☐ ER/Outpatier	nt 3 🗆 DC)A Othe			(Check only o		□Other (Spec	ify)	
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation	28e. Place	of Injury h, Day Year) of Injury - At ing, etc. (Spec	28b. Time o Injury	М		at ? ∕es 2 ⊡i	No	Bd. Describe h	Street and		ral Route Number,	
the Hospital or Attending hin 24 hours after death. the Funerel Director: After mpletely fitled in by the fune	edical Cert	29a. Certifier 1 ☐ €ertif		ien: To the	best of my kr	owledge, deat					nd due to the	cause(s) a	and manner as place, and due	stated. to the cause(s)	
To the I within 2 To the I complete	Med	29b. Signature and title of cert	K/0	and mann		7		D300					signed (Month		
5		30. Name and address of pers Donald R. F						ial	Driv	ve 0	aklan	d, M	D 2155	50	
Sta Registi		31. Date filed (Month, Day, Ye		32. R	egidirar's Sigr	nature	Arrel	30							

		1_ For State	State of Marylan	d / Dep	artment of H	lealth and M	-	•	
		Registrar		Ce	rtificate of I	Jeath	-	g. No.	31591
Physic		Decedent's Name (First, Middle, Las Michael John Can	,				2. Date of Death Month September	Day Ye	M
/Med Exami		4a. Facility Name (If not institution, give				Location of Death	1	4c. County of D	
	Į.	48 West Bishop I	ane		Smithsb	If Under 24 Hrs.		Washingt	on County Birthplace (Stete or Foreign Country)
Funeral Director		5. Social Security Number 6. Security Number 1 S	7. Age (In yrs. I XM 2 F 64		Months Days	Hours Min.	8. Date of Birth (Month, Day, May 21	Yeer) 1940	Birthplace (Stete & Foreign Country) New York
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Le	ocation				10d. Inside City Limits
he Mar 28a-f st	Funeral Director	Maryland Washingt	on Sm	ithsb	urg 10f. Zip Code			On Civina of Miles	1∭Yes 2□No
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Datitimore, Marylating Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Moulder Experiment to notified a proces.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Rican, etc.)		Vhite, etc.
72 hou	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of won	king	16b. Kind of Busine	ess/Industry
y withir liene.	omp	Elementary/Secondary (0-12)	Coilege (1-4or 5+)					Spiral S	tairs Mfg.
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uld by Menta	To E	Michael J. Canno	n			Agne	es Riorda	ın	
and lame		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, Stat	e, Zip Code)
C, N 1 and 1 and 1 ealth 1 m 27 1 her tu			wife)		West Bish			_	
Egges in its its or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Hemovai irom State	_	osition (Name of matory or other place	1		20c. Location - City	
Dallillor Dermit. Pages Department of mportant: If it any injury or o		' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License			p Veteran: 2. Name and Addres				Maryland
Dermi Depar Impou		I / / / / / / / / / / / / / / / / / / /	1 Arusless:	-			ouglas A.	Fiery F	uneral Home aryland 21742
		23a. Part1. Inter the disease, or comp shock, or heart failure. List only of	lication that caused the death						Approximate Interval Between
Physician		tmmediate Cause (Final disease or condition	one cause on each line.	(n-	/ A 0 -				Onset and Death
/Medical		resulting in death)	a Due to (or as a con > u	ence of):					(months
Examiner		Sequentially list conditions,	b						
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usasas or injury that initiated events	Due to (or as a consequ	ence or):					
out.	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
of ou,	cal		d						
OX O	Mec	tF FEMALE:	23c. If yes, outcome of pregnat	NOV.					
The law requires that the death certificate be executed as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
that the hold by deta	by Ph	Part II. Other significant conditions co	entributing to death but not resu	lting in the u	inderlying cause give	en in Part I.	23e. Did tob	aceo use contribute	e to the cause of death?
w requires t							1. Yes	s 2□No 3□	Probably 4 Unknown
law r law r nas be	Completed						24a. Was an autopsy	/ prior	autopsy findings available to completion of cause of
vical nec aician: The law s certificate has t lirector, page 2 s	ပိ				<u> </u>		perform 1 Yes 2		1? ′es 2□ No
vital iician:] certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:		Othe	NC	th (Check only one		
ding Physician: The In. After this certificate he funeral director, page	2	1 Yes 2 No	1 Inpatient 2 1	R/Outpatier 28b. Time o	IL 3 DOA	4 Nursing Ho	ome 5 Resider 28d. Describe how	nce 6 Other (S	Specify)
nding P tth. :: After	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Intury	Work	(?` Yes 2 □ No		,o.y occomod	
lor Attendi after death. Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exam	rsicien: To the best of my know iner: On the basis of examinat and manner stated.	vledge, deat on and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	onth, Dey, Year)
1		rueline	11/1/	hv	105	5623	5	extenbe	15° JOH
SH SX1		30. Name and address of person who o	ompleted cause of death (Item	28a) (Type,	Print)			•	- (
	ate	31. Date filed (Month SEP 92) 3	32. Registrar's Signat	ure L	1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** September 20,2004 4:56 A.M Rolette Cynthia Colter /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 9/20/49 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday).

55 Yrs. 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2[XF Wash., D.C. 579-66-3482 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State d other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at Yes 2 No Landover P.G. Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with U.S.A. 20785 807 Heron Ct. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Madical Exertainer 2016. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black by. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Treasury Dept. U.S. Government vrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carrie Mae Ables Sylvester Roland Jenkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 807 Heron Ct., Landover, Md. 20785 Freddie L. Colter, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/24/04 Harmony Mem. Park Landover, Md. 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. aug 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiorespiratory Failure /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially the conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Diabetes Mellitus as the burial-trag Due to (or as a consequence of) P.O. Box 68760, physiciar Hypertension Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day jo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one director Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Japital C. A hours after dec. Are real Director: Atte 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai or within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated th. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 201 11 Cl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Landover ROAD, Cheverly MD 20785 LIPISHPEE NAYAK 6501 31. Date filed (Month, Day, Year) SEP 2 3 2004 32. Registrar's Signature State 23 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day P_{M} EDITH ELIZABETH CASHOUR 2004 SEP 16 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F 87 Director 578-10-4659 Yrs. May 8, 1917 Maryland Usual Residence of Decedent with the Maryland 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
snt: If Item 27 ie marked other than "naturel", or Items 23a or 28a-f ehow ury or other traumatic event, the Medical Experiment must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland | Prince George's Forestville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6518 Insey Street 20747 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Air Elementary/Secondary (0-12) College (1-4or 5+) 12 Force Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Broadhurst May Mullineaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Seelman - Niece 21 Spinning Wheel Road, Hinsdale, Illinois 60521 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department of Importsnt: If it any injury or o Arlington National Cemetery 9/29/2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signatur of Fu Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 allust. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician MULTI ORGAN FAILURE /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). sician and burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2**∑** No Hospitsi or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No hours after death 3 Suicide 6 ☐ Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funerei [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 h and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 Sept 22 2004 30. Name and address of person o comple d cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDI AL CENTER BETHESDA MD 20889-5600 M.A.FRANZOS USN 31. Date filed (Month, Day, Year) State Registrar

		•	1 - For State Registrar	State of Mary		artment of F			Reg. No.	000	31594
	Dhuoisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Physici /Medio		Helene Margare	Clark				Septem			11:34 ам
	Examir	ier	4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o				County of Dea	
			8107 Carroll Lane	7 Ama (In	yrs. last birthday)	Silve:	r Spring			Montgon	-
	Funeral Director		5. Social Security Number 6. Sex 124-22-0232 Usual Residence of Decedent	M 25 € F	74 Yrs.	Months Days	Hours Mi		9, Year)	930 Ne	thplace (State or Foreign ountry) W York
	ryland		10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside City Limits 1 □ Yes 2 X No
	aa-f	Director	Maryland Montgome	ery S	Silver Sp			· · · · · · · · · · · · · · · · · · ·			
	or 24	Dire	10e. Street and Number			10f. Zip Code				zen of What Co	ountry?
	ath w	rai	8107 Carroll Lane			2091		(D. 7.1)		SA	dana tadina
920	s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "natural; or Items 23e or 28e-f ehow other treumetic event, the Medical Examinational Leanurities and	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever Armed Forces? 1 ☐ Yes ¾√√No If Yes, Give Year or Dates: 		Was Decedent of H If Yes, specify Cub- 1 Yes 图 No	Ispanic Origin? an, Mexican, Put Specity:	(Specify Yes of No erto Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	"natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most of w	orking	16b. Kir	nd of Business	/Industry
212	f withir piene. r then the M	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ofessor	-)		Nu	rsing	
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/lai	should be and Mental I marked o	10	Cornelius James M	lilliken			Jean	Marie S	turge	s'	
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or	Town, State, .	Zip Code)
≥,	and ealth m 27		Lloyd Clark/ Hush	and		Carroll					
ore	H ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R		20b. Place of Dispo cemetery, cre Metrop	matory or other pla-	/	tember 21.	20c. Lo	cation - City or	Town, State
Ë	Mir Hant	7	*4 ☐ Donation 5 ☐ Other (Specify)		Crema	tory	20				, Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tree		21. Signature of Fuera Service Licensee 22. Name and Address of Eacility Francis J. Collins Funeral Home Inc 500 University Blvd., W., Silver Sprin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.								
Н			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the e cause on each line.	death. Do not en	ter the mode of dyir	ng, such as card	iac or respiratory a	irrest,		Approximate Interval Between Onset and Death
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9	certificate iding phy ise as the										
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Δ.	res that the dei signed by the a be detached f	Ph	Part II. Other significant conditions cor	tributing to death but n	ot resulting in the t	underlying cause giv	ren in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
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Il Records,	The law ate has b page 2 st	Completed	П					24a. Was auto perfe 1 Yes	psy ormed?	24b. Were an prior to death?	utopsy findings available completion of cause of
Vital	tici en: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		04		eath (Check only	- '		
of	ng Phys fter this ineral di	ion: To	27. Manner of Death 1 XNatural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time (Injury	of 28c. Inju Wo		Home 5 🔼 Res 28d. Describe			ocify)
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, si Specify)				(Street and wn, State)		ural Route Number,
	ne Hospitt 24 hours ne Funere detely filler	edical C		sicien: To the best of m ner: On the basis of ex and manner stated	amination and/or in						
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens D458				e signed (Moni	h, Day, Year) O, 2004
	O		30. Name and address of person who co	empleted cause of deat	h (Item 23a) (Type						-,
			Leon C. Hwang, M	.D. 1396 E	Piccard D	rive, Roo	ckville,	MD 2085	0		
34	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 1 200	32. Registrar's	Signature	Sports					

holeelb god Crosswhite, Frank DOPS 2/13/1917 TOD 11/2 Baltimore, Maryland 21215-0036

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/Medi Examir	cal	Frank Me1 4a. Facility Name (If not					4b. City, Town, o	r Location of Deatl	Sept.	22 200 4c. County of		
Exami		Homewood					William				ington	
Funeral		5. Social Security Number	er 6. S	өх	7. Age (In yrs.				8. Date of Birt		9. Birthplace (State or Foreign Country)MISSOURI	
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land ow		Usual Residence of Dec 10a. State 10b	c. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits	
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death with the Maryland ms 23e or 28a-f show	Director	10e. Street and Number		, 2011		VV	10f. Zip Code			10g. Citizen of Wh	at Country?	
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tems	Funeral	11. Marital Status		12. Was Dece Armed For	ces?		Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		American Indian, White, etc.	
s afte	by Fi	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 XYes If Yes, Give	2 □ No e ites: W • W •		1 ☐ Yes 2 🗓 No	Specify:	,,	Specify:		
ture!			Decedent's Ed		ites: W . W .	II	dent's Usual Occup	ation		16b. Kind of Busin	White	
nin 72 in "ing Mediti	Completed		nly highest gra	de completed) College (1-	40551	(Give	kind of work done	durina most of wor	king	100. Killd of Busil	ness/industry	
ed with	mo.	9	, (0 12)	0	-401 3+)	Too1	& Produc	tion Pla	nner	Aircraf	t	
be file tal Hy d oth	Be (17. Father's Name (First	, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Sumame)		
Meni Meni Merike Merike	2	John M. Cr							dna Fraz			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Braining or other treumetic event, the Mardical Expiritive must be netitied at once.	0	19a. Informant's Name/	, ,	, ,		1	ng Address (Street					
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ages ant of nt: If it		1 X Burial 2 □ Cre 14 □ Donation 5 □	emation 3 🗆		State	cemetery, crei	natory or other place	:e)				
mit. F partme fortar injur		21. Signature of Funeral					Ven Cemet				wn, Maryland	
		190	sol .	1///	kn						aryland 21740	
		23a. Part1. Enter the dis shock, or heart fail	sease, or comp ure. List only	plications that ca	used the deat	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
hysician		Immediate Cause (Final disease or condition		. ANG	rin sile	make 1	Dio KS	Ja A	100		Onset and Death	
/Medical Examiner		resulting in death)		Due to (c	or as a conseq		3 W(V C)C3	VO Q	166		1900	
	-	Sequentially list conditio	ns,	b. Due to /c	V 26 2 CODERG	uance off:						
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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certificate nding phys use as the	Physiclan/Medlo	IF FEMALE:										
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y the d	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□ Pregna 9□ Unknov	int at time of down	eath 5∟	Other (specify)				Day Four	
s tnat tne ned by th s detache	by Pr	Part II Other significant	conditions co	ntributing to dea	ath but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?	
equires sen sign ould be	ed b	1 Phants	6						1 □ Y€	es 21 No 3	Probably 4 Unknown	
S CS	plet	The porter	JIOU						24a. Was a		e autopsy findings available	
sicien: The law certificate has t irector, page 2 s	Completed	Phyline	Duck	Orc 120	0-				autops perform	med2 deat	r to completion of cause of th? Yes 2 No	
ertific actor,	Be	25. Was ease referred to examiner?	-	(()				26. Place of Deat	- 6			
this of	2	1 Yes 2 No		Hospital: 1 ☐ In 28a. Date of		ER/Outpatien		4 Nursing Ho		ence 6 Other (Specify)	
th. After	tlon	_ /	Pending investigation	(Month	Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe no	w injury occurred		
or Attending rings after death. Director: After this (in by the funeral dir	ifica	3 Suicide 6	Could not be determined	286. Place o	of Injury - At ho	me, farm, stre	eet, factory, office	20 2010	28f. Location (St	reet and Number o	r Rural Route Number.	
s afte al Dire	Certification:	4 Homicide		building	g, etc. (Specify	v)			City or Town	, State)		
to the mospine or attended with a repaircent. The within 24 hours after death. To this Euneral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier 1 (Check only 27)	Certifying Phy	sician: To the b	est of my know	wledge, death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manne	or as stated. due to the cause(s)	
hin 24	Medi		///	and manne	or stated.							
T vitt	_	29b. Signature and title			\geq		29c. License	number Fe	Y 25	ed. Date signed (M	fonth, Day, Year)	
351	-	30 Name	nerenn urba	omnleted causa	of death /ha-	2221 /7	Print	000	9	DHO~ 60	1.6004	
, ,		30 Name and oddress of	MO C	ompleted cause	1 Joseph (Item	(1ype, 1	AMILIA	His	aNo.	2 MM	2/502	
∗ Sta	te	31. Date filed (Month, Da	y. Year)		gistrar's Signal	ture	1	- 1/4/	en reco	V	4/75	
Registr	ar	SE	P 232	004	Bellin .	1. B	perter	,				

Division of Vital Records, P.O. Box 68760,

		-	State of Ma 1- State AMEND #5, 8 per INF) 9/27/0		artment of Health tificate of Deat		lygiene Reg. No.2 11 11 11	21606
I	Physicia	an	1. Decedent's Name (First, Middle, Last) Young Chang Chae	7,25,735,007	inodio oi bodi	2. Date of Month	Death Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	Se pt	4c. County of Dea	7:40 P M
	Funeral			(In yrs. last birthday)	Fulton If Under 1 Year If Und Months Days Hours	der 24 Hrs. 8. Date of (Month,	Howard Birth 12/8/1941 _{9. Bir Day, Year) C}	thplace (State or Foreign
L.	Director		220-02-4598- 1\(\overline{X}\)M 2□ F 62 Usual Residence of Decedent	Yrs.		11-27-	-1941 Kor	
	death with the Maryland ims 23e or 28e-f show ins 25e or ordiling at	_	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Funeral Director	MD Howard 10e. Street and Number	Fulton	10f. Zip Code		10g. Citizen of What C	
	h with	ai Di	12426 Kondrup Drive		20759		II.S.A	
	ems Service	ner	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V	Was Decedent of Hispanic of Yes, specify Cuban, Mexic	Origin? (Specify Yes or ican, Puerto Rican, etc.)		
0000	al', or it	þ	1 Never Married 2 X Marned 1 Yes 2 X No 3 Widowed 4 Divorced 1 Yes, Give Year or Dates:	0	1 ☐ Yes 2 🔀 No Speci	eify:	Specify: A	sian
ה ה	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	nost of working	16b. Kind of Business	/Industry
7 7	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5-	H) /// // // // // // // // // // // // /	Businessman/	/Owner	Dry Clean	ing
	al Hygial Acther	Be C	17. Father's Name (First, Middle, Last)			other's Name (First, Mide	dle, Maiden Sumame)	
yland	d Ment d Ment narked natic e	유	Kwon Mook Chae	10h Mailie	J ng Address (Street and Nun	Jung Shin Ki		Zin Codol
Z Z	od 2 st lith and 27 is n r traun		19a. Informant's Name/Relationship (Type, Print) Chare Chae - Daughter		Greyfield B1		•	zip Code)
Jore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or liems 23s or 28s f show amounts in your popular traumatic event, the Marisal Examinar gust be notified at anone.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date 09-17-2004	20c. Location - City of Olney, MD	Town, State
Saltimor	ermit. P. epartme nportant ny injury		'4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22	. Name and Address of Fa	cility Hines-Ri	naldi Funera	al Home, Inc.
П	40 E 4 8		23a. Part Lenter the disease, or complications that caused		.800 New Hamp			Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	exia by h	anging			Interval Between Onset and Death
	Examiner		Due to (or as a	a consequence of):				~ 2 months
	be sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):				
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9/80	icate be executed physician and s the burial-transit	dicai	d					
o xog	death certifi e attending d for use as	n/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant		Testania aranganay		23d. Date of de	livery
o.	y th	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
ις Σ	requires that wen signed b hould be deta	by Pi	Part II. Other significant conditions contributing to death but	1			d tobacco use contribute t	
ora	w require been sis	ted	hypertension, hypercholesten	olemia, an	Sina pectoris			robably 4 Unknown
ı Kecoras	The law ate has b page 2 s	Completed				24a. W au pe 1 □ Ye	itopsy prior to priormed? death?	utopsy findings available completion of cause of
Vital	ucian: certific rector.	o Be (25. Was case referred to medical examiner?		Other	lace of Death (Check on		"
n or	fer	-	1 ☐ Yes 2 ☐ No 1 ☐ Inpatier 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day)	y 28b. Time of Injury	28c. Injury at Work?	28d. Descrit	esidence 6 Other (Species how injury occurred than the control of	1
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju building, etc	ry · At home, farm, str		28f. Location	n (Street and Number or R Town, State)	ural Route Number,
2	ospital c hours at uneral D iy filled ir		29a. Certifier (Check only 2 Medical Examiner: On the basis of				he cause(s) and manner a	s stated.
	the Hin 24 the Fi	Medical	one) and manner sta	ted.	29c. License numbi		29d. Date signed (Mon	
	To Cor		286. Signature and title of certifier	Deputy			1	
	62		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print) K Cone Way	Flort	4 MD 21	۸42
92	Sta	ate	31. Date filed (Mortin, Day, Tear) 32. negistra	a s signature	k cere way	TIMEDII C	19 /000 20	W (6
	Registr	rar	SED 2.1 2004 Show	now for	GOOKA!			

WAYNE M CALBY 04-6202 dap

Amended Items 10e & 19b per F.D. 10/01/2004 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		Registrar 1. Decedent's Name (First, Middle, La	State of Maryland / Dep &Unpend Item 23a&27e	Timodio or Bo		2. Date of Death	17 (7 5)	3. Time of Death
/Medic		WAYNE M	ICHAEL CALL	31	c	Month EPTEMBER	Day Year 27. 200	
Examin	er	4a. Facility Name (If not institution, giv HOWARD COUNTY GENE		4b. City, Town, or Loc COLUMBIA			4c. County of De	
Funeral Director		5. Social Security Number 6. S 212567166 Usual Residence of Decedent	Sex 7. Age (In yrs. last birthday,			B. Date of Birth (Month, Day, Ye		irthplace (State or Fore Sountry) EWYORK
e or 28a-f ehow Le notified at	ctor	10a. State 10b. County Howa	10c. City, Town or Li West	FRIEND	SHIP		·	10d. Inside City Limi
e or 28 be no	Director	10e. Street and Number 3090	Pfefferkorn Road	10f. Zip Code		10g.	Citizen of What C	Country?
	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. 13.		794	ifv Yes or No-	14. Race - Arr	nerican Indian.
naturel', or Itams 23e or 28e-f eho Jical Eranioer must be notified at	by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 M No S	Mexican, Puèrto R <i>pecify:</i>	ićan, etc.)	Black, Wh	
natu edical	Completed	15. Decedent's E (Specify only highest gra	ade completed) (Give	dent's Usual Occupation with the kind of work done during DO NOT use retired)	n ng most of working	166	o. Kind of Busines	s/industry On/Festence
giene. er then "n . Ine Medi	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		PUNCITA			AY AOVENT
d oth	Be	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle, Maid	den Sumame)	
Merke	ို	17/V / I+O/V Y 19a. Informant's Name/Relationship (CALBI	cont distance (Street and			KORBI	<u> </u>
7 Is 7 Is treu		Jeanette CALBI	/ WIFE 3000	90° rfefreerk	OTH Road	outwester, P	TTendshi	P3 COMB) 2179
of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Da	te 20c	. Location - City o	r Town, State
ment of		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	SPRING-FI	IELD Cem	10/11	2004 5	Y/Tesvill	le, mo
Department of Important: If eny injury or once.		21. Signature of Funeral Service Licer	nsee 22	2. Name and Address of	Facility JN	unBrun	17-4-41	mon co
	-		plications that caused the death. Do not en	10285ykes	Unite 140	ul ELOC	as Bing	MO 2/7 Approximate
	ai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	- Auge				
ata has been signed by the attending physi page 2 should be detached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
gne be c	ρ	Part II. Other significant conditions o	contributing to death but not resulting in the u	nderlying cause given in	Part I.		37	o the cause of death?
I	Completed					24a. Was an autopsy performed 1 Yes 2	? prior to death?	utopsy findings availal completion of cause of
cata has been s page 2 should	a)	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:	O++	Place of Death (
certificata has beer irector, page 2 shou	$\mathbf{\omega}$		1 □ Inpatient 2 X ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28	5 Residence	6 □Other (Speniory occurred	ecify)
ofter this certifica	ToB	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1			. Location (Street	and Number or R	ural Route Number,
leath. tor : After this certifica the funeral director, i	ToB	1 Natural 5 ☐ Pending		eet, factory, office	28	City or Town, St.	ale)	
4 hours after death. Eunerel Director: After this certifica ely filled in by the funeral director.	To B	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	e 28e. Place of Injury - At home, farm, str	h occurred at the time, do	ate and place, an	due to the cause	Vs) and manner a	s stated. e to the cause(s)
ofter this certifica	ledical Certification: To B	1	28e. Place of Injury - At home, farm, str building, etc. (Specify) ysician: To the best of my knowledge, death niner: On the basis of examination and/or in	h occurred at the time, do	ate and place, and n, death occurred	d due to the cause at the time, date a	Vs) and manner a	th, Day, Year)

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	State of Maryland / Department of I	Health and Mental Hygiene

Jo	ohn Mic	ha€	Carroll State Registrar	State of Maryla		artment of F			20	nı.	21500
	0	- 67.4	Decedent's Name (First, Middle)	, Last)		Timodio or	Douth	2. Date of Dea		UV	3. Time of Death
	Physic /Medi		JOHN MICHAE	EL CARROLL				Month Septemb	Day	Year	. м
	Exami		4a. Facility Name (If not institution	give street and number)	22.	4b. City, Town, o	r Location of De			2004 nty of Death	1 01:20 A.
*				450 before Rout	e 301	Bowie			Prin	ce Geo	orge's
l	Funeral Director		5. Social Security Number 217-19-5444	6. Sex 7. Age (In yrs. 1	. last birthday Yrs.	Months Days	If Under 24 H Hours Mi		r, Year)	Cour	place (State or Foreign http:/ HINGTON D.C
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				1	10d. Inside City Limits
	Mary -f sh	ठ्	MARYLAND PRINC	CE GEORGE'S B	OWIE						1X Yes 2 □ No
	h the	irec	10e. Street and Number	_ clottel b B	OWIL	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	th wit	aip	14111 WAINWRIGH	T COURT		2071.	5		U.S.		
36	d within 72 hours after death with the Maryland Jiene. Jiene. In then "netural", or Items 23a or 28a-f show The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Xever Married 2 Married	If Voc Civo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? in, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)		ace - Americ lack, White,	etc.
0	hour turat'		3 Widowed 4 Divorced	Year or Dates: 2000-						, WII	ITE
21215-0036	within ane. then *	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1.2		(Give	edent's Usual Occup e kind of work done o DO NOT use retired AURANT MAI	during most of w ()	orking	FOOD SERV		dustry
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Maryland		To B	JOE CARROLL				CYNTHI	A GRA	AHAM		
ar	2 should and Menis marker eumetic	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ing Address (Street	and Number or F	Rural Route Number	r, City or Town	n, State, Zip	Code)
	s 1 and 2 should f Health and Mer liem 27 is marke other treumetic			ATHER	1411	1 WAINWRI	GHT CT.,	BOWIE, N	1ARYLAN	ND 20	715
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from State	cemetery, cre	osition (Name of matory or other place	е)	Date	20c. Location	- City or To	wn, State
Ë	tmen tent: tent:		`4 ☐Donation 5 ☐ Other (Sp	GEO		SHINGTON			ADELPH		
Ba	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service I	4	16	6000 ANNAI	POLIS RO	AD, BOWIE	E, MARY		UNERAL HOM 20715
			snock, or neart failure. List of	complications that caused the deal only one cause on each line.	th. Do not en	ter the mode of dying	g, such as cardi	ac or respiratory arr	est,		Approximate Interval Between
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68760,	icate be executed physician and s the burial-transit	edicai		d							
_	- C S		IF FEMALE:								
P.O. Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation in Live birth 2 Feta 4 Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)				ate of deliver lonth	ry Day Year
	requires that the een signed by th nould be detache	by Ph	Part II. Other significant condition	ns contributing to death but not res	sulting in the u	inderlying cause give	n in Part I.	23e. Did tot	oacco use cor	ntribute to the	e cause of death?
<u>5</u>	w require been sig should b							1 □ Ye	s 2 No	3 ☐ Proba	ably 4 Unknown
ပ္က	law re as bee 2 sho	Completed						24a. Was a		Were autor	osy findings available
Vital Records,	و حو	mo:						autops perform 1 X Yes 2	У	prior to com death?	npletion of cause of 2□ No
<u>I</u>	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			100	26. Place of De	ath (Check only on		144 103	2 140
ot V	Physician: this certific ral director,	To	1 XYes 2 No		ER/Outpatier	nt 3 DOA Othe	r: 4 🗆 Nursing	Home 5 Reside	nce 6 Otl	her (Specify	At some
_	ng ffeit eni	ion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	?	28d. Describe ho	w injury occur	rred	that collided
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Division	after of Direction by	Certification:	4 ☐ Homicide determin		y) .			28f. Location (Str City or Town	, State)		Route Number,
	spitel ours nerel filled		29a. Certifier 1 ☐ Certifying	Physician: To the best of my kno		b occurred at the tim	e date and plac	Rt 301 , 1	Bowie	MD	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	(Check only 2 Medical E	xaminer: On the basis of examina and manner stated.	ition and/or in	vestigation, in my op	inion, death occ	urred at the time, da	ate and place,	and due to	the cause(s)
	To th: withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	29	9d. Date signe	ed (Month, E	Day, Year)
			> him	hi. m.D		O.C.1	M.E.	Se	eptembe	er 15,	2004
			30. Name and address of person w	1	n 23a) (Турв, 11 Ре юі	Print) n Street,	Baltim				
	Sta	t o	31. Date filed (Month, Day, Year)	I M.D 32. Figistrar's Signa			-VIII	Te, Hary	LCIRL 2		
:	Registr		SEP 2 (2004	H. A	hand .					

				State of Marylar	nd / Departr Cortifi	ment of I	Health and I	Mental Hy	/giene	m 1 - m		
			AMEND ITEM #20b P 1. Decedent's Name (First, Middle, L	ER FH C836 10/(05/04 JH	cate of	Deam	2. Date of De	Reg. No.	14 3	3. Time of Death	
	Physic /Med		Marthe L	ee Co	llins			Month;	mber 2	Year 2004	2:43 PM	
)	Exami		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or L		h 4c. Coun	ty of Death	0. (),	
		М	Dennett Roa	d Manor			Octlai	rd	Ga	rret	+	
	Funeral Director		5. Social Security Number 6. 235 20 8085	Sex 7. Age (In yrs. 1 M 2 F 94		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, De 9 – 18 –	V Year	Country		
			Usual Residence of Decedent	74				3-10-	1910	WANA	A, WV	
	arylar show	_	10a. State 10b. County MD GARRET	_	ty, Town or Locatio	n				10d	I. Inside City Limits	
	h the Maryland r 28a-f show	Director	10e. Street and Number	0,	AKLAND						Y Yes 2 No	
	23a or	ral Dir	706 PENSINGER	BLVD.	10	of. Zip Code 2155	0		10g. Citizen of USA	What Country	n	
Maryland 21215-0020	be filed within 72 hours eftar death with the Maryland tal Hygiene. d other then "natural; or Items 23a or 28a-f show avant, tre Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes	Decedent of I , specify Cub 'es 2 X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ice - American ack, White, etc	c	
2-0	n 72 hour "natural" edical Ex	ted	15. Decedent's E (Specify only highest gi	ducation	16a. Decedent's	Usual Occup	pation			Business/Indus		
2	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)	ring				
Ω Β	e filed v al Hygiei othar ti vant, In		1 2 17. Father's Name (First, Middle, Las	e)	HON	1EMAK)		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ESTIC		
an	ould be f Mental I arked of aric eva	Be	JOSEPH A. CRO	·			18. Mother's Nam			me)		
ary	12 should be h end Mental is marked c iraumatic ev	ဥ	19a. Informant's Name/Relationship		19b. Mailing Ad	dress (Street	and Number or Rur			State Zin Co	nde)	
	s 1 end 2 should be filed withl if Heelth end Mental Hygiene. Itam 27 is marked other then other traumatic evant, Ine M		DELILAH LANTZ	3			11th.ST.					
Baltimore,	of He of He fitam		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [Place of Disposition cemetery, crematory	/Alama of		Date	20c. Location			
tim	tment tant: I		4 ☐ Donation 5 ☐ Other (Speci	LAV	NMOOD C			/29/200	MORGAI	NTOWN,	VW	
Bal	parmit. Pages 1 end 2 Dapartment of Heelth e Important: if Itam 27 is any Injury or other tra once.		21. Signature of Funeral School Ce Lice	h d In	DER J	INGS I		HOME			√V 26505	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	aplications that caused the death	h. Do not enter the	mode of dyir	ng, such as cardiac	or respiratory a	rest,	· · · · · · · · · · · · · · · · · · ·	oproximate terval Between	
4	Physician			ES						Or	nset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Preumo	nia					3	weeks	
		Je.		Due to (o	r as a consequence	e of):						
	cuted nd ransit	Examiner	Sequentially list conductors	b. Due to for	r as a consequence	e offic						
90,	ificate be executed g physician and as the bunal-transit	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							ŧ		
68760,	cate b physic the b	edical	that initiated events resulting in death) Last	Due to (or	as a consequence	of):						
Box 6			L	d								
ğ.	daath e etter d for u	Iclai	Part II. Other significant conditions of	antributing to death but not see	dia a in dia a sa a sa da		D. 20.	1				
0.	that tha daath cer ed by the ettendir detached for use	by Physician/N	E La						obacco use co ∕es 2∭2 No	ntribute to the 3 □ Probabl	e cause of death?	
Ś	es tha igned be de	by F	atherisclent	c ceralova.	scyler	dise	ase		25/110	3 - Tiobaoi	y 4 Donkhown	
Division of Vital Records, P.O.	Attending Physicien: The law raquires that tha daath cer ricds: Atta. Control Atta. Other His certificate has been signed by the ettendin by the fundral director, page 2 should be deteched for use	Completed	Liabetes	c cardiova. me litus	type	two)	24a. Was a perfor	an autopsy med?	availat	autopsy findings ble prior to	
Rec	sicien: The law certificate has t irector, paga 2 s	I I I			1/					of deat	etion of cause th?	
tai	iclen: The certificate rector, pag		25. Was case referred to medical					1 U Y	/-	1 □ Ye	es 2 No	
Ž	ysicle s cert direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	DOA Othe	26. Place of Death er: 4 Nursing Hor			or (Coorie)		
0 0	ding Phys h. Aftar this funaral di	ä	27. Manner of Death 1 Natural 5 ☐ Pending	1	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe h				
sio	leath. for: Al	catle	2 Accident investigation 3 Suicide 6 Could not b		М	10'	Yes 2□No					
Σį	or At aftar o Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fac)	ctory, office	2	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Ro	ute Number,	
	spital	a C	29a. Certifier (Chack orb.) 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Hospital or Attendii within 24 hours aftar daath. To the Funaral Director: A completely fillad in by tha fu	edicai	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	on and/or investiga	tion, in my op	e, date and place, a pinion, death occurre	ed at the time, d	ause(s) and ma ate and place,	and due to the	cause(s)	
	To the Complete Compl	Σ	29b. Signature and title of certifier	11	1/10	29c. License			9d. Date signed			
			1 Holling	Mun	-uv	DO	125756	1 5	epten	per 2	5,2004	
	5		30. Name and address of person who was the ref.	completed cause of death (Item	23a) (Type, Print)	OBO	247	Accide	nt M	0215	20	
	Sta Registra	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati		00				-		

		r	1 - State Registrar	Maryland / Depa	artment of Health and Martificate of Death	•	
	Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
	-/Medi		Ann V. Chapin			Sep. 15,	2004 12:00 a M
7	Exami	ner	4a. Facility Name (If not institution, give street and num	,	4b. City, Town, or Location of Death	4c. Co	unty of Death
			Chesapeake Hospice House 5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	Linthicum If Under 1 Year If Under 24 Hrs.		ne Arundel
L	Funeral Director		191–20–6458 Usual Residence of Decedent	76 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 3,1928	9. Birthplace (State or Foreign Country) PA
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show to Madical Examilier must be notified at	tor	MD 10b. County Anne Arundel	10c. City, Town or Lo	Annapolis		10d. Inside City Limits 1 ☐ Yes 2 ➡ No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10g. Citizen	of What Country?
	23e	<u>a</u>	1034 Lake Claire Drive		21401		USA
	er de	une	Amed Ford	lent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. I	Race - American Indian, Black, White, etc.
215-0036	nours afte urel', or l	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 If Yes, Give Year or Dat	No No	1 ☐ Yes 2 ∑ No Specify:		ecify: White
5	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of workir DO NOT use retired)	16b. Kind o	f Business/Industry
212	withi iene. then	d mc	Elementary/Secondary (0-12) College (1-4	for 5+)	Homemaker		Homo
	filed Hygid Sther ent, II	a)	12 17. Father's Name (First, Middle, Last)			(First, Middle, Maiden Sun	Home
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. I then "naturel", or Items 23e or 28e-1 show item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event. If a Modical Examiling must be notified at	ToB	Alphonso Vasile Alfonso 19a. Informant's Name/Relationship (Type, Print)	Vasule Vasile	Mary Ar	ntonette Rocc	20
	1 and 2 s Health ar tem 27 is		William Scott Chapin/Sor	822	g Address (Street and Number or Rura Chestnut Tree Dri	ve, Annapoli	s, MD 21401
Baltimore,	80= 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place)	16,	on - City or Town, State MOre, MD
Balt	permit. Pag Department Importent: any njury o		21. Signature of Funeral Service Licensee	Ba 49	Name and Address of Facility rranco & Sons, P.A 5 Gov. Ritchie Hwy	A. Severna Pa	rk Funeral Home
	Physician /Medical Examiner		232-Fan1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each lmmediate Cause (Final disease or condition resulting in death) Due to (or	ised the death. Do not enter th line.	or the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
8760,	rate be executed hysician and the burial-transit	Ilcal Examiner	cause. Enter Underlying Cause (Ulsease or injury that initiated events c.	as a consequence of): as a consequence of):			
P.O. Box 6	t the death certific by the attending p ached for use as	Physician/Med		n 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)		Date of delivery Month Day Year
rds, F	w requires tha been signed I should be det	by	Part II. Other significant conditions contributing to deal	h but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
ř	ate ha	Completed				24a. Was an 24t autopsy performed?	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
o	this aldiu	To Be		atient 2 ER/Outpatient	3	e 5 Residence 6	ther (Specify)
DIVISION	Attending Property of death. sctor: After in the funeral property in the funeral property.	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, 2 Accident investigation 3 Suicide 6 Could not be		Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occi	
5	prital or A rurs after brel Direc illed in by		4 Homiciae	Injury - At home, farm, stre etc. (Specify)		City or Town, State)	nber or Rural Route Number,
:	to the hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	Medical	29a. Certifier (Check only one) 1	s of examination and/or inve	occurred at the time, date and place, an sstigation, in my opinion, death occurred	at the time, date and place	a, and due to the cause(s)
ŀ	co d will	_	250. Signature and title of certifier	7	29c. License number		ned (Month, Day, Year)
			// // N	V	V005144	SKPT	enber (5204
			30. Name and address of person who completed cause of	MO 90	VOOS(30) CO Bergate A	L) Suite 700	Annypolis 00
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2004	strar's Signature	and I		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PEARL B. DRESSEL 10:05 PM 2004 Sept 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis ElderCare - The Pines Talbot Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) JAN 31 1920 Birthplace (State or Foreign NEW YORK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 XF 84 Yrs Director 578-16-8194 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits oriant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Modical Exercities must be notified at 1 Yes 2 No TALBOT EASTON Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No WHITE Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK CIRCUIT COURT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ROBERT E. BRADLEY KATHLEEN WARNOCK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN G. WANNER/DAUGHTER 28176 OAKLANDS RD EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9-25-2004 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY EASTON, MARYLAND 21. Signature of Funeral Service Licensee **See *** PECERS *** PELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA *** 200 S. HARRISON ST EASTON, MD 21601 MHOL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arrhentlemin mountal. **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Yes 2 No Certification: To Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner_stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie NO

Registrar

State

MICHALL

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

egistrar's Signature

ROWLE

			1 - For State Registrar	State of Maryla	nd / Dep		Health and		_	2/502	
	4		Decedent's Name (First, Middle, Last	st) -				2. Date of Death	1400	3. Time of Death	
	Physici			DUISE DON	hVA	2		Month () G	Day Year	3:00 pm	
	/Media		4a. Fecility Name (If not institution, give		0 0 1 1		or Location of Dea	1	4c. County of Dea		
	Examir	ier	Carroll Hospital				minster		Carro		
	Funeval		5. Social Security Number 6. S		s. last birthday)			8. Date of Birth			
	Funeral Director			□M 2FFF	83 Yrs.	Months Days	Hours Min	July 29	ear) G	thplece (State or Foreign ountry) MD	
est.			Usuel Residence of Decedent		05	1		July 25	1921	1-117	
	ylan		10a. State 10b. County		City, Town or Li					10d. Inside City Limits	
	Mar Fig.	tor	MD Carr	oll	₩e	estminste:	r			1 ☐ Yes 2 ☐ No	
	1 28 m	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?	
	23a C	a D	625 Woodside Dri	ve		2	1157		USA		
	hours after death with the Maryland tural, or Itams 23a or 28a-f ehow at Executive court be the lifted at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame		
2	or its		1 Never Married 2 Marned	1 ⊟Yes 2√290 If Yes, Give	ł			to Ficari, etc.)	Bleck, Whit		
3	rai',	l by	3 Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: M	hite	
Ö	22	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	ation	dking 16	b. Kind of Business	/Industry	
7		nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)				
7	T	Con		2	F	egistere	d Nurse		Medical		
2	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma.	iden Sumame)		
2	D 2 2 7	2	Carl L. Knabe				Frieda	a Dederer			
0	d 2 shou h and M 7 ie mar traumat		19a. Informant's Name/Relationship (•• •	1.5	-		ural Route Number, C			
			Elaine Conover/d					Westminst	er, MD 2	1157	
Dalulliole,	ges 1 an t of Heal if item 2 or other		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other pla	ce) 9/:	23/2004 20	c. Location - City or	Town, State	
	Pages nent of int: # it		* A ☐ Donation 5 ☐ Other (Specification 5 ☐ O	Detiloral libit State		n Memoria	1 .		Finksbur	a, MD	
	permit. Pag Department Importent: I eny injury o		21. Signature of Funera Service Licen	-			4	ne and Chaj			
ŏ	Per F ag		10/10		F	ritts fu	neral Hor	ne and Cha	per, P.A.	21157	
r	9		23a. Part1. Enter the disease, or com	plications that caused the de	ath. Do not en	ter the mode of dyir	ngton Koa ng, such as cardia	ad Westmin	nster, ML	Approximate	
			shock, or heart failure. List only Immediate Cause (Final	/	DEA	JAL F	TAILUR			Interval Between Onset and Death	
'	hysician /Medical		disease or condition resulting in death)	a ACUTE		ا ۱	71010			lweek	
	Examiner		1	Due to (or as e conse		P HE	ter B	HLURE		1 Week	
		-	Sequentially list conditions,	b. Due to (or as a conse		0 110		1700		1 00664	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,						
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	C Due to (or as a conse	equence of):						
20,	e be ex rsicien e burial	catE									
-	m 2 0			d							
8	The law requires that the death certificate into has been signed by the attending physicage 2 should be detached for use as the terms.	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregi	22001						
200	ath c	lan	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Y						
	at the de by the a tached t	/sic	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5L	Other (specify) _				,	
Ĺ	d by letac	Phy	Part II. Other significant conditions c	ontabuting to death but not co	aultina in the	a dark in a acusa au	on in One)	220 Did tohan		the course of death?	
ń	ires that signed I	by	rattii. Ottier significant conditions c	onthibuting to death but not re	southly in the u	riderlying cause giv	en in ran i.		X 1	the cause of death?	
5	w requir been si should	ted						1 🗆 Yes	2 2 No 3□Pr	obably 4 Unknown	
Vital necolds,	has by	Completed						24a. Was an autopsy	prior to	atopsy findings available completion of cause of	
		On						performed	d? death?	2 No	
<u>a</u>	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical				26. Place of De	ath Check on one			
	lysic direc	2	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatier	al 3□ DOA Oth	er: 4 Nursing H	lome 5 Residenc	e 6 Other (Spe	cify)	
	ig Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at	28d. Describe how			
5	Attending ir death. ector: After by the fune	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □No				
DIVISION	Atte	ific	3 Suicide 6 Could not be determined	289. Place of injury - At	home, farm, sti	eet, factory, office		28f. Location (Stree		aral Route Number,	
5	tal or Attending Pr s after death. al Director: After the ed in by the funeral	Certification:	- I comede	building, etc. (Spec	ary)			City or Town, S	Ha(0)		
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical C	(Check only 2 Medical Exan	ysician: To the best of my kr niner: On the basis of examin	nowledge, deat	h occurred at the tir	ne, date and place	, and due to the caus	e(s) and manner as	stated.	
	the lin 2. the f	led	Uney	and manner stated.							
	with To	2	29b. Signature and title of certifier		_	29c. Licens			Date signed (Monta		
	MS		Tranco	K. Galusi	I MO	105	1660	0	1/21/200	24	
	5		30. Name and address of person who	· · · · · · · · · · · · · · · · · · ·	MARKET PROPERTY.	Print)				21159 R MARY CONV	
			THOMAS K.	GALVIN TI	1 2	91 570	NER AVE	rue lue	STMINSTE	r mary conv	
	Sta		31. Date filed (Month, Day, Year)	32. Regisfar's Sign	nature	,					
	Regist	rar	SEP 2 1	LUUA DERGER	, 16	bout,					

		1- State of Maryland / Depart Certi	ficate of Death	Reg. No	1001. 21602
Physic /Med		Decedent's Name (First, Middle, Last) Agnes Emmons		Date of Death Month Day eptember 2	
Exam			b. City, Town, or Location of Death	4c.	. County of Death
- Europa			Frederick If Under 1 Year If Under 24 Hrs. 8.	. Date of Birth	Frederick 9. Birthplace (State or Foreign
Funera Directo		228-26-5032 1 M XXF 88 Yrs.	Months Days Hours Min.	(Month, Day, Year) ay $10, 191$	16 Virginia
and		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion		10d. Inside City Limits
Maryl I-f eho	ţ	Maryland Frederick Frederick	 		1. Yes 2 □ No
ith the	Directo	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
s 23a	ral	2088 E. Greenleaf Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21702		ited States 14. Race - American Indian.
of the de street	Funeral	1 Never Married 2K Married 1 ☐ Yes 2 K No	as Decedent of Hispanic Origin? (Specifics, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.
DO3(d by	3 Tridowed 4 Divorced 16al of Dates.	Yes 3 No Specify:		Specify: White
and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Ind other than "natural; or items 23a or 28a-f ehow event, the Medical Example at a secont.	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kir life, DC)	nt's Usual Occupation nd of work done during most of working ONOT use retired)	16b. K	ind of Business/Industry
d withingliene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Medical	Technologist	Не	ealth Care
V -	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	2	William Irma Mays 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing.	Lottie Address (Street and Number or Rural R	Milholler	· · · · · · · · · · · · · · · · · · ·
Ma nd 2 si utth an 27 is u			. Greenleaf Drive		ck, MD 21702
of Hee		20a Method of Disposition 20b. Place of Dispositi			ocation - City or Town, State
Baltimore, permit. Pages 1a Department of Hee Importent: If Item and injury or other pages injury or other pages.		'4 □Donation 5 □Other (Specify) Thornrose			aunton, Virginia
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic events.			Name and Address of Facility Staut 521 Opossumtown Pil	ffer Funei ke Fredei	ral Homes, P.A. rick, Maryland 21702
		23a. Part . Enter the disease, occomplications that caused the a Do not enter nock, or heart failure. List only one cause on ear line.	the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
Physician /Medica		Immediaté Cause (Fnal disease or condition resultifig in death)	Cordin Vasach) Lise	re 10Ars
Examine		Zue to (or as a consequence of):			
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or fijury			
xecute and Il-trans	Examiner	that initiated events resulting in death) Last			
18760, cate be executed physician and the burial-transit	cal E	d			
r 68 artificat ing phy		IF FEMALE:			
. Box 68 death certificate attending plot of for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 menths?	ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
p.O. that the de	hyslo	1 Tyes 2 No 9 Unknown 9 Unknown	THIST (Specify)		
ds, P.O. I uires that the de signed by the a id be detached id	þ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		use contribute to the cause of death? No 3 \(\text{Probably} \) 4 \(\text{Unknown} \)
Records, the law requires to the has been signed age 2 should be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
— L 20 G	Com			performed? 1 ☐ Yes 2 X No	death?
of Vital Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death /(4	
Phy Pris	n: To	27. Manner of Peath 28a. Date of Injury 28b. Time of	3 DOA 4 Viursing Home	5 Residence	
Attending F r death. ector: After	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of or Attending after death. Director: After d in by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 28f	f. Location (Street an City or Town, State	nd Number or Rural Route Number, B)
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of and manner stated.			
To the within To the compl	₹	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
		X-apr/2. Janfman	D-13971	9/	21/04
		30. Naille and address of person with perted cause of death (Item 23a) (Type, Pr		(A1472)	
5	tate		et Frederick, Mar	yland 217	701
Regis		SEP 2 2 2004 Server S	Sparks		

			For State Registrar		f Maryla	and / Dep	artmen <i>rtificat</i>					Reg. No.	2001	31601
	Physicia		Decedent's Name (First, Middle,								2. Date of De Month	Day		3. Time of Death
	/Medic	al -	Mary		Sarner						09	18		11:46 AM
	Examin	er	4a. Facility Name (If not institution,				,		Location (of Death			County of Dea	th Georges
			Prince Georges 5. Social Security Number	Medical 6. Sex		rs. last birthday		ever	⊥y ∷If Under	24 Hrs	9 Date of Bir			rthplace (State or Foreig
	Funeral Director		579-66-3143 Usuat Residence of Decedent	1 M 2⊠F	54	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da		C	halie, VA.
and	A TI	-	10a. State 10b. County		10c.	City, Town or L	ocation				-			10d. Inside City Limits
ће Магу	8a-faho	ector	D.C. 10e. Street and Number			Washing		Codo			···	10a Citi	zen of What C	M∏Yes 2☐No
with	9 2	늄	108. Street and Number				10f. Zip		•			rog. Citi		ountry
aath	s 23	era	2629 17th. Stree	12. Was Dece	dent Ever i	0115 13	Was Dece	2001		inin2 /Sn	ecify Yes or No)-	USA 14. Race - Am	erican Indian
filed within 72 hours after death with the Maryland	artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or itams 23a or 28a-f ahow injury or other traumatic event, the Medical Exeminer mast be politised at 8.	Completed by Funeral Director	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	rces? 2 ⊊ No ∕e	13.	It Yes, spec				ecify Yes or No Rican, etc.)		Black, Whi	ite, etc.
hour	tural al E	Par l	15. Decedent'		a.63.	16a Dece	edent's Usua	al Occup	ation			16h Ki	nd of Business	Andustry
in 72	a Ta	Set	(Specify only highest	grade completed)		(Give	kind of wo	rk done d	<i>durina</i> mos	t of work	ing	100.11	114 01 0 0 0 1 1 1 1	
with	thar thar	E C	Elementary/Secondary (0-12)	College (Pos	tal W	arka:	r			II C	Gover	nmant
filed	Hygiene. other than	Ö	17. Father's Name (First, Middle, L		rs.	FUS	Lai W	JIKE.		er's Nami	e (First, Middle			ument
eq p	ced c	o Be	Joseph H. Garn	er. Sr.					E1s	ie C	rews			
should	and Mental is marked o	ို	19a. Informant's Name/Relationsh	-		19b. Maili	ing Address	(Street			al Route Numb	er, City o	r Town, State,	Zip Code)
and 2	Health ar tem 27 is other trau		Tameka Garner/D	aughter		2629	17th	. St	. N.E	. Wa	shingto	on, I	.C. 20	018
1 3	of He f Item r oth		20a. Method of Disposition	2		 b. Place of Dispersion cemetery, cre 	osition (Nar	ne of ther plac	e)		Date	20c. Lo	cation - City or	Town, State
	Department o Important: If any injury or once.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	Fort Li	ncoln		9	-24-	-04	Brei	ntwood,	MD.
permit.	Department Important: I any injury o once.		21. Signature of Funeral Service L	icensee	60	2	2. Name ar	d Addres	s of Facili	^{ty} Mar	shall's	s Fui	neral H	ome
P	Impo any ir		J. P. M.	aishal	e						Washi			
/1	ysician Medical taminer	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Sep	or as a con sis S or as a con nary	rculator sequence of): yndrome sequence of): Tract In sequence of):								
death certifical	ed by the attending physician detached for use as the burial	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 🗀 F nant at time	etal death 3	⊒Ectopic pi ⊒ Other (sp						23d. Date of de Month	livery Day Year
requires that the	s been signed by should be detai		Part II. Other significant condition		eath but not	resulting in the t	underlying o	ause givi	en in Part I		23e. Did t	obacco u	se contribute t	o the cause of death?
quire	an sig	ed	Alcoholic He	patitis							1 🗆 '	Yes 22	No 3∏P	robably 4 Unknown
sician: The law requires t	has b	Completed by	Congestive He	eart Fail	ıre								death?	utopsy findings available completion of cause of
			25. Was case referred to medical	11					26. Place	of Deat	1 ☐ Yes h (Check only o		1016	3 2 110
Physician:		To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🗷	Inpatient :	2 ER/Outpatie	nt 3 DC	Oth					3 □Other (Sne	ecify)
ling Phy	within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di													
or Attending		Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) M 1 ☐ Yes 2 ☐ No 28f. Location (Street City or Town, Sta						Street an wn, State	d Number or A)	iural Route Number,	
Hospital	24 hours Funeral etely filled	edical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the examiner: On the b and man	best of my asis of exan	knowledge, dea nination and/or ir	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
o the	o the	Me	29b. Signature and title of certifier		0		290	c. Licensi	e number			29d. Dat	e signed (Mon	th, Dey, Year)
Ē	(5)		V K. Hw	Loef X	egr			00	052	865	5	Sep	+ 20	2004
	Go.		30. Name and address of person with the Michael Fig.	//				ive	Char	70×1··	, MD (2070		
	Sta	te	31 Date filed (Month, Day, Year)		3001 tegistrar's S	Hospit	aı DI	ıve,	Chev	егту	, PID. 2	20/03	,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 18 **Physician** 2004 SAMUEL EDWARD GLISAN 11:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11122 Green Valley Road Union Bridge Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Fe 60.8, 1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 78 Mary Tand 216-22-8249 Yrs. Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location , or Items 23a or 28a-f ahow animer plust be notified at 10d. Inside City Limits 1 TYes 2 No Maryland Frederick Directo Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11122 Green Valley Road 21791 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic evant, the Medical Examiner 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 Divorced Specify: White "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "ni any injury or other traumatic evant, The Media once. Elementary/Secondary (0-12) Coilege (1-4or 5+) artificial inseminator Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) S. Orla Glisan Maude Condon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11122 Green Valley Rd. Union Bridge, Md. 21791 Treva E. Glisan/wife 20b. Place of Disposition (Name of cometery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State nlace) 1 X Burial 2 □ Cremation 3 □ Removal from State Johnsville U.M. Cem. |Sept.21,2004 Johnsville, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses 11802 Liberty Rd. Libertytown, Md. 21762 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Con onst-16 outlet /Medical Due to (or as a consequence of) Examiner em () Sequentially list conditions, if any least the Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Dther: 4 | Nursing Home 52 residence 6 | Other (Specify) 1 ☐ Yes 2 ☐ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident s after dec. 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Zed no 014626 5 cpt 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) non St. Frederick MD 21701 MUUS 64 MD 501 31. Date filed (Month, Day, Year) 32. Recittrar's Signature State Glown & Spark Registrar

			State of Maryland / Department / Department / Departm		lental Hygier	OOO	31606
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir	al	James Cornelius Grice Sr. 4a. Fecility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		r 19,2004 4c. County of Death Frederic	
	Funeral Director	· ·	5. Social Security Number 6. Sex 2 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yea	9. Birth	place (State or Foreign ntry) TimgRE MS
	the Maryland 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Montgomery 10c. City, Town or Lo				10d. Inside City Limits 1 Yes 2 ☐ No
	with the Manuel B or 288-f	Director	10e. Street and Number 191, 22, SENERY DR.	10f. Zip Code	10g. (Citizen of What Cou	ntry?
36	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Evaminat must be multind ut	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Tyes 2 10 No	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: BL	
21215-0036	within ane.	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing	Kind of Business/Ir	
Maryland 2	be filed ital Hygi of other event, I	To Be Co	17. Father's Name (First, Middle, Last) SYLVESTER GRICE	w///	(First, Middle, Maid		sh
	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		19a. ormant's Name/Relationship (Type, Print) 19b. Maili BETTY MAE GRICE 20a. Method of Disposition 20b. Place of Dispo	ng Address (Street and Number or Rura CMOTTER AVE. position (Name of	FRES. 1	y or Town, State, Zip NJ . 3() Location - City or To	101
Baltimore,	Pages ment of H ent: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	J Cem. 9-2	4-04 F	Es. Ms	•
Balt	permit Pag Department Importent: I any in ury o		Hary C. Kollens 1		T. FRED. (11NS FUNE 2170	
	Prysician /Medical Examiner	8 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac o	or respiratory arrest,	ľ	Approximate Interval Between Onset and Death O Y & A \(\)
8760,	cate be executed ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	(3)			10 4 & ARS
. Box 6	The law requires that the death certifics to has been signed by the attending pto page 2 should be detached for use as to a second to the seco	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
rds, P.O	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to to	he cause of death?
Vital Records,		Completed			24a. Was an autopsy performed?	prior to co death?	ppsy findings available mpletion of cause of
Vita	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpaties	Other	n (Check only one) me 5 ☐ Besidence	6 □Other (Specif	(v)
Division of	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b	f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how in 28f. Location (Street City or Town, Ste	jury occurred and Number or Rura	
Ō	spital or nours afte neral Dir / filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, a	and due to the cause	(s) and manner as s	tated.
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to	o the cause(s)
	with To	Σ	29b. Signature and title/pf eprifier	29c. License number D - 31912		Date signed (Month,	
	-7		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	Sta	ate.	JUNO FRENCE TO, 1564 OPOSSUM ZOW 31. Date filed (Month, Day, Year) 32. Registrar's Signature	N PIUG FAZDER	ill, mD	21702	
	Regist	1 100	SEP 2 2 2004 Beneva /	4 Sparker			

DHMH 17 Rev 1/2001

Registrar

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SEP 1 6 2004

RJ 04-05922 Brian Heid

ria	n Heid		1- State of Maryland	•	artment of rtificate o		•	giene		31608	
425-	Physici /Medic		1. Decedent's Name (First, Middle, Last) Brian Daniel H	eid			2. Date of De Month		Year	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center			or Location of Deverly	Death	4c. County	y of Death		
	Funeral Director			st birthday) 2 Yrs.	If Under 1 Yea Months Day		Min. Dec 1	, 1 981		lace (State or Foreign	
with the Maryland	be filed within 72 hours atter death with the Maryland ital Hygiene. Italygiene dother than "natural", or itema 28s or 28s-f show event. The Medical Examinar must be notified at	ai Director		Town or Lo				10g. Citizen of U.S	What Coun	0d. Inside City Limits 1 ☐ Yes 2 No try?	
9036	nours after dea ural', or itema I Examiner mi	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Message No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Co	uban, Mexican, P	? (Specify Yes or No- guerto Rican, etc.)	Specif	***************************************	ite	
Maryland 21215-0036	filed within 72 r Hygiene. Ither than "natu ort. he wedica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last)	(Give	dent's Usual Occ kind of work dor DO NOT use reti Roofer	ne during most of red)		(g Cons Co.	struction	
lanc	ould be to Mental Parked of artic ever	To Be	Jerome Charles Heid				Name (First, Middle, e Carroll:				
	nd 2 sho alth and 27 is ma r traum		19a. Informant's Name/Relationship (Type, Print) Jerome C. Heid				Crozet, V		State, Zip		
	Pages 1 a ment of Hes ant: If Itam ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Ponation 5 Other (Specify)	ce of Dispo netery, cren Mation Cen		ineral 9	Date 1-27-04	Chanti	-	_{wn, State} Virginia	
Balt	permit. Page Department important: if any injury or once.		21. Signature of Funeral Service Livensee	CF5P2	2. Name and Add	lson Blv	Murphy Furd., Arling	gton,Va			
	Medical Examiner	resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
.O. Box 68760,	the death certificate be executed by the attending physician and ached for use as the burial-transit	Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	cy eath 3	Ectopic pregnar	ncy			te of deliver	ry Day Year	
Records, P.(w requires that the de been signed by the s should be detached t	by	by	Part II. Other significant conditions contributing to death but not resulting to the feether was the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to death but not resulting to the conditions contributing to the conditions conditions conditions conditions conditions conditions conditions conditions conditions conditi	ing in the ur	nderlying cause (given in Part I,	23e. Did to	4.		e cause of death?
I Rec	Ine law ate has b page 2 sl	e Completed	25. Was case referred to medical			26 Place of	24a. Was a autop perfor Yes	sy med? 2□No	prior to com death?	sy findings available apletion of cause of	
ivision of	ding Pnys h. After this funeral dii	Certification; To B	The state of the s	P/Outpatien 8b. Time of Injury le, farm, stre	28c. In W	Other: 4 Nursing Nursi	28d. Location (S	ence 6 Oth ow injury occurr cut b	e of	en	
:	To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Stack only one) 1 Certifying Physician: To the best of my knowledge of the control of the control of the control of the certifier 29b. Signature and title of certifier	edge, death n and/or inv	vestigation, in my	time, date and pl	occurred at the time, o	late and place,	and due to	the cause(s)	
,	T wit		Left mo			.M.E.		29d. Date signer Septemb		*	
\mathcal{C}	RB		30-yeme and address of person who completed cause of death (Item 2	11	Print) Penn	Street,	Baltimore	, Maryl	and 2	1201	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2 2004	ho	de						

			1 - For State Registrar	State of M	larylar		artment e rtificate			and M	1ental Hy	giene	nn	11.	31609
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De			Year	3. Time of Death
	Physici /Medic		HELEN		HALI						SEPTEM	BER	15 2	2004_	9:45 P M
	Examir	er	4a. Facility Name (If not institution, give)		4b. City, To	_		of Death				of Death	
	Funeral		Prince George's 5. Social Security Number 6. Se		ge (In yrs.	last birthday)	If Under 1		erly If Under	24 Hrs.	8. Date of Bir				orge's lace (State or Foreign
	Director		216-30-6278	⊐м 2 छ F	70	Yrs.	Months [Days	Hours	Min.	8. Date of Bin (Month, Da Septem	_{ay, Year)} ber	6	Coun Mary	lace (State or Foreign try) land
	pur		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ty, Town or Lo	action								
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	h with		3103 Good Hope A	venue # 3	303		20748						. S . A		, .
	deatl	Funerai	11. Marital Status	12. Was Deceden	t Ever in U	J.S. 13.		nt of His	spanic Ori	gin? (Spe	ecify Yes or No		14. Rac	e - Americ	
36	s after	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	No		1 ☐ Yes 2 ☐		Specify:	, ruento	riican, etc.)		Specify	ck, White, e	
Ö	hour: tural'	ed b	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates		162 Dogge	ient's Usual (200100	tion			4.05 14:			lack
5	n "na	Completed	(Specify only highest grad	de completed)	F.)	(Give	kind of work of NOT use	done di	uring most	of work	ing	160. KI	na or Bi	usiness/Ind	lustry
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nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			•			18. Mothe	r's Name	(First, Middle	, Maiden	Su <i>m</i> an	10)	
<u>Y</u>	Ment Ment Marke	L _o	William Hall								rie Whi				
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (7)	* * *											Code) 20743
e,	1 and Healt Iem 2		Monique Johnson, 20a. Method of Disposition	Daughter	20b. F	6510 Place of Dispo	Centr sition (Name	a⊥ of	Ave.		02 Capi			hts.	Maryland on State
JOI L	ages ant of nt: If II		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		'			er place		9/21	/04			•	,Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Mardicul Evantmat has relatined at once.		21. Signature of Funeral Service Licens		MOS	ses Cem		Address			B. Jer				
ä	Der Imp		+ K. D. Mar	shall							Landov				20785
i.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each	d the deat	th. Do not ent	er the mode o	of dying	, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Seps										- 18	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a											
		40	Sequentially list conditions,	b. Gang		Rt Leg								_	
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oʻ	an and	Еха	resulting in death) Last	Due to (or a:							-				-
8760,	icate be executed physician and s the burial-transit	dicai		_{d.} Diab	etes	Mellit	us								
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	40	IF FEMALE:	23c. If yes, outcome	a of pregna	ancv					_				
Box	death atter	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	ıl death 3 □	Ectopic pregr					2	Mor	e of deliver nth [y Day Year
0.0	that the de led by the a detached t	hys	9 Unknown	9 Unknown											
	signed I	ру Р	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	iderlying caus	se giver	n in Part I.		23e. Did to	obacco us	se contr	ibute to the	cause of death?
ord	w require been si should	ted									10	Yes 2	□ No	3 Proba	bly 4 Unknown
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												rmed? 2₩ No	1	leath?	2 🔯 No
Viital	ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ont 2	ER/Outpatien	3 DOA	Other	~		(Check only o				
jo (g Physier this ieral di	H .	27. Manner of Death	28a. Date of Inj (Month, Di	ury	28b. Time of		Injury	at		ne 5 🗌 Resid 28d. Describe f				
Ö	ittending F death. ctor: After / the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(MORUI, DI	iy roar)	Injury	М	Work?	es 2 🗆 N	lo					
Division of	or Attendatter deatt	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At he tc. <i>(Specif</i>	ome, farm, stre	eet, factory, of	ffice		2	28f. Location (S City or Tox		l Numbe	er or Rural	Route Number,
	pitel ours at serel D		300 Coddies 45 Coddies Bh	1-1	-/					#					
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medicel Exami	ner: On the basis of and manner s	of Axamina	wiedge, death ition and/or inv	occurred at t estigation, in	my opi	nion, deat	l place, a h occurre	and due to the o ad at the time,	cause(s) a date and	and mar place, a	nner as sta ind due to t	ted. he cause(s)
	ro the	Me	29b. Signature and title of certifier	4.04	11		29c. Li	icense	number			29d. Date	signed	(Month, D	ay, Year)
	VC		> KMM	wy	/		D	16	27	3		9-	-23	3-00	7
	3		30. Name and address of person who co	ompleted use of	h (Iten	п 23а) (Туре, І			- <i>\unu</i>						
			Rebathy Murphy M				ad Che	ever	1y, 1	Mary	1and 20	785			
	Sta Registr	-	SEP 2 3 2004	32. Regist	rar's Signa										

	1 - For State Regist
18	1. Deceden
ician dical	Sarah
niner	4a. Facility
	Villa

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	Reg. No.	U	U	1.5	

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Physician
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/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

	1. Decedent's Nam	_								2. Date of I Month	Death	Day	Year	3. Time of	
	Sarah		₹.	Jordan	n					9		16	2004	6:0)5p [\]
1	Villa Ros	sa Nurs	ing Home				Mi	tche.	llvi1					orge's	
	237–38–39	953	6. Sex 1 □ M 2 🔏 F	7. Age (In yrs. 90	V	Months Months	Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I July	Dav. Ye	1914	Cour	lace (State on try) Hill,	
\vdash	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside Ci	tv Lîmit
	MD	Prince	George's			dover	_							1 □ Yes	
-	10e. Street and Nu		ocorge :	•	Lan	10f. Zig					10g.	. Citizen of	What Coun		
	7503 Twi	ining C	ourt				207	85				.S.A			
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ı	Elementary/Seco 7th	indary (0-12) 1	College	(1-4or 5+)	Domes							P	rivat	e	
7	17. Father's Name Samue1		Last)						er's Name	(First, Midd		_{den Suma} rdan	me)		
-	19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Maili	ng Address	s (Street a	and Numbe	er or Rura	l Route Num	ber, C	ity or Town	, State, Zip	Code)	-
1	William H	H. Webb	/Son		7503	Twini	ing C	Court	I	andov	er,	MD	20785		
	20a. Method of Dis	position			Place of Dispo cemetery, crei	sition (Nar	me of			ate			- City or To	wn, State	
	1 LX Burial 2 1 4 □ Donation		3 □Removal from Specify)		ck Gro	ve Ba	ptis	t !		2004			ill, :		
	21 Signature of Fu	ineral Service	Licensee							. Jenl					
	2	< BC	/			474 I	ando	ver I	Rd.	Lende	over	, ID	2078	85	
	Immediate Cause disease or condition resulting in death) Sequentially list confirm and the confirm and the cause (Disease or that initiated events resulting in death)	nditions, nmediate	b. Due to	Adult F (or as a consect Dementi (or as a consect (or as a consect)	quence of): La quence of):	to I	Chriv	re						week	
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Ī	25. Was case refer examiner?	red to medica	1					26. Place	of Death	(Check only	one)				
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2	27. Manner of Deat 1 Xatural 2 Accident	h 5 🗌 Pendir investi		of Injury nth, Day Year)	28b. Time of Injury	f 2	28c. Injury Work 1 🗆 `		2	8d. Describe					
	3 Suicide 4 Homicide	6 Could determ	not be nined 28e. Plac build	e of Injury - At h ding, etc. (Speci	ome, farm, str fy)	eet, factory	y, office		2	28f. Location City or To			ber or Rural	Route Numb	oer,
	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the Examiner: On the and man	e best of my kno basis of examina nner stated.	owledge, deati ation and/or in	n occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the	e cause e, date	ə(s) and m and place,	anner as sta and due to	ated. the cause(s)	
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		/ W.											3/1//	2004	
		. 1	who completed cau	1	m 23a) (Type, 9500 An				Suit	e #A4	Lá	nham	, MD 2		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 340UNG otenber 19 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTI MORE
If Under 1 Year If Under 24 Hrs. MARIS STELLA BALTIMORE HOSPITAL 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 F Yrs. Director 213 63 7568 Usual Residence of Decedent NOVEMBER 5, 1980 death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Directo MD HOWARD ELLICOTT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DR VIEW 8632 TRAIL 21043 KOREA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Maryland 21215-0036 $^{\prime\prime}$ illed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 le marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MYUNG 500 ၉ JUNG SOON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND permit. Pages 1 and 2 Department of Health a Importent: If item 27 le sny injury or other trac once. DR. SEVNG 8632 VIEW ELLICOTI CITY MD 21043 CHEUL KIM TRAIL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 9.22-04 ALEXANDRIA METROPOLITAN 21. Signature of meral says e Lice see 22. Name and Address of Facility CHRRLES HINDS FUNERAL SERVEE 12363 KAYAK DR. VPPER MARLBORG MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2010 CULVEL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medlcal the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence & Other (Specify) NOSPICE Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this hours after death. Inerel Director: After this y filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0 9/20/2004 410854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

SEP 2 2 2004

Riseberg

30,

Baltimore

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Marie Katherine Knotts September 24, 2004 1:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 55 Preston Lane 0akland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F Director 82 5, 1922 West Virginia 235-44-2578 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mantal Hygiana. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examinar mant be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 55 Preston Lane
11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wotring Ethe1 Helmick 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 55 Preston Lane, Oakland, Md. 21550 Carl L. Knotts/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/28/04 Leadmine, WV Shaffertown Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acute Myocardial Infarction hours Examiner Due to (or as a consequence of): by Physician/Medical Examiner Coronary Artery Disease years cartificate has been signed by the attanding physicien end lirector, page 2 should be detached for use as the buriel-trensit or Attending Physician: The law requires that the deeth certificate be executed Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco usa contributa to the cauaa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D0023979 09/27/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Robert A. Goralski, M.D. 311 N Fourth St Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 Registrar 2004 ORIGINAL

DHMH 16 Rev 6/95

			For State Røgistrar	State o	f Marylan		artment rtificate			and M	lental Hyg F	jiene lag. No. 0	Contraction of the second	31614
T			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		HASE	LEAH ETT.	A KAHL						SEPTEMB			7:00 P M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, 1	Town, or	Location of	of Death		4c. Coun	ty of Death	1
			406 N. FOURTH)AKL		Od Ura			RETT	
	Funeral			6.Sex 1 □ M 2 X OXF	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	Col	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	7171	76						JUNE 1	, 1928	L.WV	
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Man)	to	MD GARR	ETT		DAKLAN	D							1 ₹Yes 2 □ No
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	death with the Maryland ms 23a or 28a-f show r must be rivitified at		406 N. FOURTH	STREET					1550				USA	
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7 7	d within giene. ir than	Completed	Elementary/Secondary (0-12)	2		SEC	RETARY	7				INS	URANC	E
	be filed tal Hygir d other event, I	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Nam	e (First, Middle,	Maiden Suma	ıme)	
<u> </u>	should b ind Menti i marked umatic e	2	MARK SNYDER			_					EPILON.			
	~ ~ ~ ~		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	r, City or Tow	n, State, Z	îp Code)
	s 1 and 3 if Health item 27 other tr		KARL KAHL-HUSB	AND	20h F	406 1	N. FOU		ST.		LAND, M	215 20c. Location		Town State
0	Se to I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	emetery, cre	matory or of	her plac	1				,	
altimore,	permit. Pag Department Important: I any Injury o		' 4 ☐ Donation '5 ☐ Other (Sp 21. Signatus of Fugeral Service L		01	1EGA CI	KEMAT() 2. Name an	_			1, 200	4 MORGA	ANTOW	N, WV
Ra	permit. Page Department of Important: If any Injury of once.		Med 1 Ha	Que	M001					•	P.O. B	37 2/2	OVE	21550
			23a. Part1. Enter the disease, or	complications that	caused the deat	100							UAIX	Approximate Interval Between
	Physician		shock, or heart failure. List of Immediate Cause (Final	•										Onset and Death
	/Medical		disease or condition resulting in death)	a. Alzł Due to	eimers (or as a consec	uence of):	e dem	ent	1a					b≨ yr
н	Examiner		Carecrately list ecoditions	acut	e cere	brov	scul	ar	acci	den	t			7 wks
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	and and I-trans	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consec	uence of):	_						_	
8760,	death certificate be executed e attending physician and of for use as the burial-transit													
289	ficate phys s the) Da		0								1		
Rox	eath certific attending p I for use as 1	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	itcome of pregn	ancy	75-4					23d. C	ate of deli	very
ň	death e atte d for	icla	in the past 12 months? 1 □ Yes X□ No	4 Preg	birth 2 ☐ Feta nant at time of c		□Ectopic pro □ Other <i>(sp</i>					N	fonth	Day Year
o.	that the de led by the a detached f	Physiclan/Medical	9 Unknown	9□ Unki	nown									
	56 50	by F	Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	inderlying ca	ause give	en i n Part I	•				the cause of death?
Vital Records,	w require been si should b										1 🗆 Y	es 2.DXNo	3 [] Pro	obably 4 Unknown
ပ္ပိ	has be	Completed									24a. Was autop	an 24b	. Were au	topsy findings available completion of cause of
<u>~</u>	(0) ++	Son									pertoi 1 ☐ Yes	2√ No	death? 1 ☐ Yes	2 No
<u> </u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamitali				Oth	or		h (Check only o			
<u></u>	Physic this caldina	2	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2	ER/Outpatie		8c. Injun	÷ 4∐ NU	ursing Ho	me 5 XResid		- ' '	eify)
ב	tending Physician: leath. tor: After this certific the funeral director,	lon	1 XNatural 5 Pending	, ,	of Injury oth, Day Year)	Injury	M	Worl	k? Yes 2□	No	200. 00001120 1	on injury cook	31100	
Division of	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury - At h	ome, farm, st					28f. Location (S	treet and Nun	nber or Ru	ral Route Number,
<u> </u>	를 를 들	Certification;	4 Homicide	build build	ling, etc. <i>(Speci</i>	fy)					City or Tow	m, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	al	29a. Certifier 1 XCertifyin	g Physician: To th	e best of my kn	owledge, dea	th occurred	at the tin	ne, date ar	d place,	and due to the	cause(s) and r	nanner as	stated.
	he Ho in 24 he Fu pietel	ledical	(Check only 2 Medical i	xaminer: On the and ma	nner stated	ation and/or in				un occur				
	To t To t	Σ	29b. Signature and title of certifier	116	1/1	40	290	. License	e number			29d. Date sign	ed (Month	n, Day, Year)
			1 Jona		Julie	2nd		3003	35			09-26	-200)4
	10		30. Name and address of person											_
		ate	Donald R. 31. Date filed (Month, Day, Year)		M.D. Registrar's Sign		3 Men	ori	al I	riv	e Oakl	nad,	MD 2	1550
	36	arc	SEP 2	200 J	Ela-	Ro	18 0	2 -						

			1- For Amend Item 2	State of .5,27,28	Marylan a-f per	nd/Depa	artment of F	lealth ar	nd Mental H s	ygiene Reg. No. 11	11 7	
	0		Decedent's Name (First, Middle, Last						2. Date of D	Death		3. Time of Death
	Physici		Janice Maxine	Long					Secre	Dev 21	2004	13250 M
)	/Medic Examin		4a. Facility Name (If not institution, give	street and num	nber)		4b. City, Town, o		Death	4c. County	of Death	
ı			Washington Coun	ty Hosp	ital			gersto			Washi	ngton
	Funeral Director		5. Social Security Number 6. S 220-18-0599	ех □м ЖЖг	7. Age (In yrs. 88		If Under 1 Year Months Days			Birth Day, Year) 13, 1916	9. Birthpla Count Mar	y land
	PG ≥		Usual Residence of Decedent 10a, State 10b, County		10c Cit	v. Town or Lo	cation				10	d. Inside City Limits
	sho	'n	,		100.01	•						1 ☐ Yes XX No
	289-1	Director	Maryland Washin	gron		WIII	i amsport		· · ·	10g. Citizen of V	What Count	n/2
	with 3a or			lana				795			SA	.,.
	ms 2;	Funeral	10702 Appletree	12. Was Dece	dent Ever in U	.S. 13. \	Vas Decedent of H	lispanic Origin	? (Specify Yes or I	No- 14. Rac	e - America	
20	2 hours after death with the Maryland atural; or items 23a or 28e-1 show ical Examinat the multified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Tes If Yes, Give Year or Da	2 🛣 No e		fYes, specify Cuba I⊡Yes 2 🛣 No	Specify:	Puerto Hican, etc.)	Specify	ck, White, e v: Wh	
2-003c		ted	15. Decedent's Ed			16a. Deced	lent's Usual Occup	ation		16b. Kind of Bi		
מ	within 72 ene. than nat	Completed	(Specify only highest gra	College (1	-4or 5+)	life. l	kind of work done OO NOT use retired	1)	_			
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	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						Name (First, Midd		·	
<u> </u>	d Men narke natic	2		enberger		10h 14ailia			ia Anatl		erman	3-4-1
Ma	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (or Rural Route Num			
<u>စ</u> ်	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Ludwig M. Long — 20a. Method of Disposition	Husband	20b. F	Place of Dispo	sition (Name of		e William Date	20c. Location -		
9	e = 5		1 Deurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		state		natory or other place	´	+ 24 2004	William	cmort	Maryland
saltimore,			21. Signature of Funeral Service Liver		Gre		Borne Affic		t.24,2004	WILLIAM	SpOI I	,Maryland 21795
ñ	permit. Departrimports any inji		1	1					ague St.	Williams	port,	
	1		23a. Part1. Enter the disease, or com shock, or heart fail re. List only	plications that ca	aused the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ULMD	NARY	AP	PECT			Onset and Death
	/Medical		resulting in death)		or as a conseq			1110	200			
	Examiner	L	Sequentially list conditions,				AC	1005	is			
	ted	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq		i i i i i i i i i i i i i i i i i i i	TUXI	/iTV			
,	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (E TAM or as a conseq	uence of):	riei			1116	-0/	m
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g		a a						CF	RTIFICATION APPRO	NED BY WILL		
X Q Q	death certifi e attending p id for use as	lcian/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pregnancy	,				
о П	the dea by the att	ysici	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	4□Pregna 9□Unkno	ant at time of d		Other (specify)			Мо	ntn L	Day Year
Į.	that the ed by detac	/ Physi	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Dio	I tobacco use conti	ribute to the	cause of death?
SD	law requires that the di as been signed by the 2 should be detached	ed by							10	Yes 2 No	3 🗌 Proba	bly 4 DUnknown
Hecord	m v ou	Completed							24a. Wa	s an 24b.	Were autop:	sy findings available
	sician: The lav certificate has irector, page 2	mo:							per 1 Yes	formed?	death?	pletion of cause of □ No
Vital	sian: artifica ctor,	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check only			
0	Physician: this certific al director,	2	1 X Yes 2 ≥ Ne			ER/Outpatien		4 🔲 (40) 5	ing Home 5 Re			
	fter free	lon:	27. Manner of Death	14.00	of Injury h, Day Year)	28b. Time of Injury	Wor	k?		how injury occurr	'ed	
DIVISION	death death stor: / the	ertification:	2 Accident investigation 3 Suicide 6 Could not b	DITION		Unknow		Yes 2 X No	OHICHOW	n (Street and Numb	er or Rural	Route Number
2	al or Attending P s after death. il Director: After i id in by the funera	ertii	4 - Homicide A determined	Unknow		y)	eet, factory, office		City or T	own, State)	0, 0, 1,0,0,1	rodio valibor,
	pit	O	29a. Certifier 1 Certifying Ph	ysicien: To the	best of my kno	wledge, death	occurred at the tin	ne, date and p	Unknow	e cause(s) and ma	nner as sta	ed.
	he Hos n 24 hc he Fun pletely	edical	(Check only 2 Medicel Exar	niner: On the ba and mann	sis of examina	ition and/or inv	estigation, in my o	pinion, death	occurred at the time	a, date and place,	and due to t	he cause(s)
	To the within To the comple	M	29b. Signature and title of certified	1 .			29c. Licens	e number		29d. Date signed	(Month, D	ay, Year)
			MUN	/	1 · D		DOO	614	1 /	Supt.	22,	7004
,	it a		30. Name and address of person who	4	e of death (Item	n 23a) (Type,	Print) A	MODE	Rd Hage	rstown	Mar	yland
Í	Sta	ate	31. Date filed (Month, Cap. Xear)	32. Re	egistrar's Signa	ature	icaci (a	100/100	- ' /			
•	Regist		oer 23	2004	Tagen .	4 /	And Wall					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3 Time of Death Day 20 **Physician** ROBERT MACDONALD 5.30 PM september 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min 15 M 2 ☐ F Director 213-58-1639 Apr 9. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23e or 28e-f shov 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Reisterstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 328 Norqulf Rd. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "neturel", or items 23e enty injury or other treumetic event, the Medical Experimentation. 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Disabled none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carter MacDonald Mary Kuhlman ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reisterstown, ID 21130 20c. Location - City or Town, State 328 Norgulf Rd.

20b. Place of Disposition (Name of cemetery, crematory or other place) Wife Mangala MacDonald 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 9/21/04 4 Donation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atia Amyotrop his Privsician 2011 /Medical Due to (or as a cons+ uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter outrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. I the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an , page 2 s certificate 2 No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 2 1 ☐ Yes _2XNo 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Physician MSZ Name and address of person who completed cause of death (Item 23a) (Type, Print) Raynor Blvd Suite A Pasadena 2 Nnaemeka 31. Date filed (Month, Day, Year) 32. Registrar's Signature leave & Sparke Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			30	ate of Ivia	i yiaiiu /	Certifica		Death	, ,	Reg. No.2 0 0 L	31617
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		3. Time of Death
	Physici /Medi		Julia Lucile McAllis	ter					Sept.	22, 2004 Year	1335
	Examir		4a Facility Name (If not institution, give street	end number)				4b. City, Town, or Lo	ocation of Death	4c. County of De	ath
			1062 South Potomac S	treet				Hagersto			ington
	Funeral		5. Social Security Number 6. Sex		(In yrs. lest b	Month:	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. B	irthplace (State or Foreign Country)
	Director		220-28-3739	ta r	73	Yrs.			March 1	15, 1931	Maryland
	pu ≱		Usual Residence of Decedent 10a. State 10b. County	····	10c. City, Tov	vn or Location					10d. Inside City Limits
	Mary	ō	Maryland Washington	,	На	gerstown	,				1 ☐ Yes 2 No
	the 128	rect	10e. Street and Number		II.		ip Code			10g. Citizen of What C	Country?
	Sa or	Ö	1062 South Potomac	Street				21740			ISA
	death	Jera	11. Marital Status 12. W	as Decedent Ev	ver in U,S.	13. Was Dec	edent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		nerican Indian,
0	after of the second	Fur	1 Never Married 2 Married 1	med Forces? ⊒ Yes 2∭ No Yes, Give)				Rican, etc.)		
02	ralf, c	by	3 ☐ Widowed 4 ☐ Divorced	ear or Dates:		T Tes	ZMINO	Specify:		Specify: W	nite
Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Hems 23a or 28a-f show ont, the Medical Examiner must be notified at	To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade com		16a	Decedent's Us	ual Occup	ation during most of work d)	ina	16b. Kind of Busines	s/Industry
121	within than the Me	mpj	Elementary/Secondary (0-12)	ollege (1-4or 5+)			d) -			.1 -1 -
2	Hygier ther th	ဝိ	12	0		cler	C	18. Mother's Name	- /Firek Adiabatic		il sales
an c	be fi	Be	17. Father's Name (First, Middle, Last) Samuel E. Younker					Ruth He		Maideri Surriame)	
ž	should nd Men marke umartic	٩		*-*	140	A4 . 12 A . I . I	(0)			. O T O	7. 0. (.)
Za	d2 st th end 7 is n traur		19a. informant's Name/Relationship (Type, Pr Thomas J. McAllister			_				r, City or Town, State, own, Maryl	
	i end 2 should be Health end Mental em 27 is marked o other traumatic eve		20a. Method of Disposition	- IIusba		of Disposition (Nary, crematory or				20c. Location - City o	
Baltimore,	S to to		1 ☐ Burial 2 XCremation 3 ☐ Remov	al from State		ny, crematory or stown C:			-23-04		m, Maryland
Ħ	permit. Pege Depertment of Important: If any injury of once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	0.0	nager					FUNERAL H	
Ba	Dep Impo		SINTO	1///	nn S						
			23a Part I Enter the disease of complication	or that coursed the	ha death Do	J					yland 21740 Approximate
and the same	Dharisian		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ise on each line	i.	not onto the inc	oc or ayır	ig, odor as cardiae (or respiratory arr	031,	Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final	R	2001	-+	0	2)me			LHOOLY
	Examiner		disease or condition resulting in death) a		to to (or as a	consequence of		20110			1 georg
34	-6.	اةٍ ا			ue to (or as a	consequence of	<i>y</i> -				
	The law requires that the death certificete be executed ste has been signed by the attending physicien end page 2 should be deteched for use es the bunel-trensit	Examiner	Sequentially list conditions,	D	ue to (or as a	consequence of):				
0	e exe ien e uriel-	Ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
68760,	ete b hysic the b	Physician/Medical	that initiated events resulting in death) Last	Di	ue to (or as a	consequence of):				
9 ×	entific ling p	₹ E	d								1
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	the g	ysic	Part II. Other significant conditions contributi	ng to death but	not resulting	n the underlying	cause giv	en in Part I.	23b. Did to	bacca use contribut	te to the cause of death?
P.0	v requires that the death cer been signed by the attendin should be deteched for use	Æ							1 □ Y	es 2/2No 3□1	Probably 4 Unknown
of Vital Records,	rires sign ld be	d by							24a. Was a	in autopsy 24b	. Were autopsy findings
00	beer shou	ete							perfor		available prior to completion of cause of death?
Re	has ge 2	Completed							47.74	. X	
B		ပိ	25. Was case referred to medical					26. Place of Deatl	h (Chack only or	2410	1 Yes 2 No
5	Physician: The law this certificete has t rel director, page 2 s	To Be	examiner? 1 Yes 2 No Hospita	ıl: 1 □ Innatient	2 ER/O	utpatient 3□ [Oth		/	ence 6 Other (Sp	ecify)
0	arthis erel o		27. Manner of Death 28a	Date of Injury (Month, Dey		Time of	28c. Injur			ow injury occurred	outy
ioi	ndlng eth. r: Afte	atio	2 Accident 5 Pending investigation	(Month, Dey 1	rear)	Injury M		Yes 2□No			
Division	ecto by th	E E	3 Suicide 6 Could not be determined 286	e. Place of Injury building, etc.	y - At home, fa	arm, street, facto	ry, office		28f. Location (Si City or Town	treet and Number or F	Rural Route Number,
Ö	rs eft	Certification:			(=,,,					,,	
	tospi 4 hou uner ely fil	cai	29a. Certifier (Check only 2 dedical Examiner: O	To the best of a	my knowledge xamination ar	e, death occurre	d at the tin	ne, date and place, pinion, death occurr	and due to the c	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
	To the Hospital or Attending Phys within 24 hours eiter deeth. To the Funeral Director: After this completely filled in by the funerel di	Medicai	one) a	nd manner state			9c. Licens			9d. Date signed (Mor	.,
	७ ₹ ७ ७	-	29b. Signature and title of certifier		4		T. LIUGIS	1.(1.4-	2	09/12	6 //
	, iX	}	Tud Me	m	_da	MID	1	7041)	01/20	104
	H		30. Name and address of person who complet	ed cause of dea	in (item 23a)	(Type, Print)	3	001 0	T. +	Lagonst	21740
.6.	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1120	2 0	THE	1	indemi	GWI , IND
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 16 2004 **Physician** SYLVIA MYERS 4:00 A M /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 11311 Sherrington Court Prince Georges Upper Marlboro | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | 03-10-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕱 F 83 Yrs. Director 212-20-1133 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "natural", or items 23a or 28a-f show treumatic svent, the Medical Examinar must be notified at Director DC 1**∑**Yes 2 No Washington, DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4217 Massachusettes Ave. S.E. USA 20019 death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Cosmetoligist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Savoy 2 Maude Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda West/ Daughter 4217 Massachusettes Ave. S.E. Washin ton, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State parmit. Pages
Department of H
Important: If ite
any injury or ol
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery A □ Donation 5 □ Other (Specify) 9/22/2004 Davidsonville, MD 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Coronary artery disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): 68760 Physician/Medical as Box IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 certificate Division of Vital 1 Yes 2X No Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify)Hospice Hospital: P 1 🗌 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni after 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 29a, Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057400 9/16/2004 N mu. nomas, mos 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Lynn Thomas M.D. 1221 Mercantile Lane Upper Marlboro Maryland 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

1 - For State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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٥	JAMES M. SA	YLER				E.	GRACE	RIFFL	Ε		
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			For State Registrar	State of Man		artment of F			ene	91691
			Decedent's Name (First, Middle, L.)	ast)		timouto or	5 6 6 6 7	2. Date of Death	1	3. Time of Death
	Physicia		Francis J. McAd	ams, Jr.				Month Septembe	Day Year r 20, 200	4 1:10 ам
	/Medic Examin		4a. Fecility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Dea		4c. County of Dea	th
			Holy Cross Hosp	ital			Spring		Montgo	mery
	Funeral			Sex 7. Age (I. 1 ☑ M 2 ☐ F	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Bir	thplace (State or Foreign ountry)
	Director		026-12-2013 Usual Residence of Decedent		79 Yrs.			Jan. 3,	1925 Ma:	ssachusetts
	land ow		10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	Mary First	to	Maryland Montgo	merv	Silve	Spring				1 ☐ Yes 2 No
	h the	Director	10e. Street and Number	1// 2	DIIVE	10f. Zip Code		10	g. Citizen of What Co	ountry?
	238 c		321 University	Blvd, West,	#112	20901			USA	
	tems tems	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 1XT Yes 2 □ No If Yes, Give Year or Dates: W	WIT	1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh:	
8	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23a or 28e-f show ia Madical Exaindrat mast be indiffied at	edt	15. Decedent's 8			dent's Usual Occup	ation	1	6b. Kind of Business	
21215-0036	n "na Nedis	Completed	(Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retired	during most of wo	rking	ob. Kind of Eddings	madatty
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Неа	ad Chef			Restaurar	nt
	e filed al Hygia l other vent, I	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle, M	aiden Sumame)	
Maryland	Ments Ments arked atice	To	Francis J. McA	dams, Sr.			Elizab	eth Timmo	ns	
lar	2 should be finand Mental Fis marked ot raumatic ever		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, State, .	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents If item 27 is marked other then "naturel; or Items 23a or 28e-1 show any injury or other traumatic event, the Madical Examination in the profiled at once.		Dottie Costopou	Los/ Daughte	20b. Place of Dispo		Lane, Ol	ney, MD 2		-
0	Pages nent of Hent. If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	cemetery, cre.	matory or other place of Heaven	Sept	ember 23	0c. Location - City or	Town, State
Baltimore,	rtmer rtent rtent njury		* 4 □ Donation 5 ☑ Other (Spec 21. Signature of Juneral Service Lice		Ceme	eterv		2004 s	ilver Spri	ng, Maryland
Ba	permit. Departr Importe any inj		21. Signatur of fulleral service Lice	Qle Cole				Funeral id., W., S.		ng, MD 20901
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the						Approximate Interval Between
E	Pnysician _I		Immediate Cause (Final disease or condition	_aPnoumoni						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						
	Lamine		Sequentially list conditions,	b. Septicem						
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ve Heart	Fodlumo				
	al-tra	xar	that initiated events resulting in death) Last	C. Due to (or as a co		rallule				
8760,	cate be executed physician and the burial-transit	icai		d. Coronary	Artery I	Luctue				
9	Attending Physicien: The law requires that the death certifics rideath. rdeath. sctor: After this certificate has been signed by the attending ply the funeral director, page 2 should be detached for use as it	Med	IF FEMALE:							
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
0	that the de led by the a detached t	ysic	1 Yes 2 No	4□Pregnant at ti <i>m</i> 9□Unknown	e of death 5L	Other (specify)				
٥.	that I		Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	urres signe	d by						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Munknown
00	w requir been si should	iete						24a. Was an	24h Were au	itopsy findings available
Re	he lav e has age 2	Completed						autopsy performe	prior to death?	completion of cause of
	en: T	0	25. Was case referred to medical	T			26 Place of De	1 ☐ Yes 2 ath (Check only one)		2 No
\geq	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Impatient	2 ER/Outpatier	nt 3 DOA Oth			ce 6 Other (Spe	cify)
Division of Vital	ng Ph ter th		27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor	y at	28d. Describe how		
Sio	endir sath. or: Ay	atic	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Ë	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not determined		 At home, farm, str Specify) 	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
	urs a		00-0-10-	4						
	Hosi 24 ho Fune Fune	Medicai	29a. Certifying P (Check only one) 2 Medical Exa	thysician: To the best of m miner: On the basis of ex and manner stated	a <i>m</i> ination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occi	e, and due to the cau arred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier	and manner stated		29c. Licens	e number	290	d. Date signed (Monti	n, Day, Year)
:				ine -	معود از از	т	1.N.10		glast	2001
	3+1		30. Name and address of person who	completed cause of death			060619		1/10	7004
			Connie Le, M.D.	1500 Fores			Spring.	MD 20901		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1				
	Registr	ar	SEP 21 20	04 Green	f.J	sporks				

		1 - For State Registrar	State of Ma	aryland		rtment tificate			nd Mer		giene Reg. No.	1004	31522
		1. Decedent's Name (First, Middle,	Last)						2.	Date of De Month	ath Day	Yeer	3. Time of Death
Physic		JOAN	L.				ma	GUIR	28 3	cotem	July .	6,200	1 6:49 M
/Med Exam		4e. Facility Name (If not institution,	give street and number)			4b. City, 7	own, or L	ocation of I	Death		4c. 0	County of Deel	th
Funera Directo	1		NS HOSPITA Sex 7. Ag	L e (In yrs. Ia 63	st birthday) Yrs.	Brt LT If Under Months		If Under 24	Min.	Date of Bir (Month, Da 11y 4,	th y, Year) 194	l Co	hplace (State or Foreign bunty) nington D.C.
υ		Usual Residence of Decedent		I									And toolds Challimin
nylan ihow		MD. Montgor	n 0 1637	1	Town or Lo ville	cation							10d. Inside City Limits 1 Yes 2 XNo
e Ma	cto		mery	ROCK	VIIIC	1					10 000		
ith th	Direction 1	10e. Street and Number				10f. Zip					USA	en of What Co	ountry !
ath w	a	528 Azalea Dr.	10 Was Danadan	Fuer in 11 S	112.1	208		annie Origie	n2 (Specifi	v Vos or No		4. Race - Ame	encan Indian
Deficiencies, Ividal yield A. I. Z. I. 2000. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experimental to notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		1	Yes, spec		Mexican, I	Puerto Ric	y Yes or No an, etc.)		Black, Whit	
2 hou	ted	15. Decedent's	Education		16a. Deced	ient's Usua kind of wor	l Occupati	on	of working		16b. Kin	d of Business	/Industry
thin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT us	e retired)	nng mosi o	n working				
d wit	Completed	12			Busir	iess (eting	
VICE OF THE About HIS Abou	To Be	17. Father's Name (First, Middle, La John Cattis	ast)						Werne	First, Middle E Y	Maiden S	Sumame)	
and h		19a. Informant's Name/Relationship	o (Type, Print)			•						Town, State,	
y IVICAL and 2 st alth and 3.27 is r		Kelly Murphy, d	aughter					ill T		- +			, Md. 20852
Dallillore, Dermit. Pages 1 a Department of Hei mportant: If item iny injury or othe	>	20a. Method of Disposition 1		CO	ace of Dispo metery, cren surect	natory or of	her place)		Date 20/20			ton, Mo	
Dentit. Department imports any inju	NIE.	21, Signature of Funeral Service Li	2		W	isc. A	lve.,	NW.,	WDC	2001	.6	s Sons	Inc., 5130
death certificate be executed death certificate be executed extreming physicien and death certificate as the burial-fransit	icai Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		a consequ A consequ	ence of):	ailu							Interval Between Onset and Death 24 hours
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pro					2	3d. Date of de Month	livery Day Year
the the	þ	Part II. Other significant condition	s contributing to death t	out not resu	iting in the u	nderlying c	ause giver	in Part I.			obacco us Yes 2		o the cause of death?
age h	Completed									24a. Was auto perfe			utopsy findings available completion of cause of
VITAL P Vicien: Th Certificate rector, pag	Ф	25. Was case referred to medical						26. Place o	of Death (C	Check only			
IN OT VITA ing Physician: Wer this certific uneral director,	on: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Kinpati 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury	f 2	8c. Injury a Work?	al	280	5 Resid. Describe		Other (Spe	ocify)
DIVISION OF VITAL tor Attending Physicien: 1 after death. Director: After this certifical in by the funeral director, p	Certification:	2 Accident investigated as Suicide 6 Could not determine	ot be 28e. Place of In	ijury - At ho tc. (Specify	me, farm, str	M reet, factory		es 2 N		Location (City or To			ural Route Number,
Hospite 4 hours Funerel ely fillec	Medical C		Physician: To the best xaminer; On the basis of and manner st	of examinat									
To the within 2 To the complet	Ne.	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (Mon	th, Day, Year)
		Tracy J. Wom	er, Medical	Doct	700		RES	-00	0		Scoter	mber 1	6,2004
(0		30. Name and address of person v	no completed cause of		23а) (Туре,		100 41	o A TH	(DOLF				65, JOB 2018
	State strar	31. Date filed (Month, Day, Year)	32. Regist	trar's Signat		1	cks						

			1 - For State Registrar	State of Ma	aryland / Dep	artmen	t of H	ealth a	and M	ental Hygi	ene		01100
			Decedent's Name (First, Middle, Last	st)						2. Date of Deat	1	-	3. Time of Death
	Physici		Carol Rachel Man	tz						Month Septemb	er 19.	Year 2004	7:15 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. County		
			13717 Strafford D	rive		Th	nurmo	ont			Free	leric	
	Funeral		5. Social Security Number 6. S	ex 7. Ag □M 2√xxF	e (In yrs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, April 11	Year)		ace (State or Foreign try)
	Director		317-42-4477		61 Yrs.					April II	, 1943	Indi	ana
	land w		10a. State 10b. County		10c. City, Town or Le	ocation						10	Od. Inside City Limits
	the Marylar 28a-f show	ţō	Maryland Frederi	ck	Thurmont								1 ☐ Yes 2 🕱 No
	or 288	lrec	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	Vhat Coun	try?
	23a c	alD	13717 Strafford D	rive				L788			Unit	ed S	tates
	172 hours after death with the Maryland "naturel", or Items 23a or 28a-f show calcul Examir net instituted at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Deced If Yes, spec	ient of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
36	s afte	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 ☐ I If Yes, Give Year or Dates:	ຶ່ ¹ 960–	1 ☐ Yes	216 No	Specify:			Specify	· Wh	ite
9	turel turel	edt	15. Decedent's Ed		16a. Dece	dent's Usua	al Occupa	ation		1	6b. Kind of Bu		
15	n "na	plet	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of wor DO NOT us	rk done c	turing mos	t of worki	ng			,
21215-0036	be filed within 72 hours after death with the Maryla Ital Hygtene. Id other than "naturel", or Items 23e or 28e -f show event, the Medicul Exament: ust be mulified at	Completed	12		' 1	eamst	ress				Custo	m Des	ign
nd	be filed tal Hygi d other svent, t	Be (17. Father's Name (First, Middle, Last)							(First, Middle, N		θ)	
yla	2 should be and Menta Is marked aumatic ev	2	Robert C. Vessey							L. Thomp			
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship			-				il Route Number,			
	ss 1 and 2 of Health item 27 r other tr		George C. Mantz]	II / Husb	20b. Place of Disp	osition (Nan	ne of			Thurmor	Oc. Location -		
Baltimore,			1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specifi		Resthaver	matory or o	ther plac		Sept.	25,			
I	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licer								rederio		
Ba	Depar Impor any ir		1/1/1/1/		R 9	estha 501 Ca	ven	Funer tin M	al S ltn.	ervices, Hwy. Fre	Skkot	Cody	P.A. 21701
	(Ar		23a. art). Enter the disease, or open shock, or heart failure. List vily	plications that caused								, 115	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		STAGE LIV								Onset and Death
	/Medical		resulting in death)		a consequence of):								
	Examiner		Sequentially list conditions	U		cin	ritu	Siz	DV-	Live	1		3 YEARS
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as	a consequence of).								
	be executed ician and burial-transil	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):								
760,	be execusician and burial-tra	calE		٠,٠	,								
687	ficate g physics ts the											-	
Вох	eath certificat attending phy I for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pr					23d. Date	e of delive	y
-	0 0 0	lcia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		Other (sp					Mor	nth	Day Year
P.0	that the death	Physician/Med	9 Unknown										
	8 2 9	by	Part II. Other significant conditions of CANLEY		out not resulting in the C	ındərlying c	ause give	en in Part I		23e. Did tob	_		e cause of death?
ord	w require been sig should b	eted			BNEAST	- 1							
Sec	e la has e 2	Completed	LAMIEN	0 4	121,5 14 20					24a. Was ar autopsy perform	, 0	Vere autop rior to con leath?	sy findings available pletion of cause of
Vital Records,										1 ☐ Yes 2	No 1		2 No
V.		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	nt 3□ DC	Othe			ne 5 PReside	-	- /Cassifu	
of		I	27. Manner of Death	28a. Date of Inju (Month, Da			8c. Injury Work			28d. Describe ho			,
ion	nding F ath. r: After e funer	ation	1		y Year) Injury	М		<br Yes 2 □	No				
Division of	r Attendi er death rector: A by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of in	ury - At home, farm, st	reet, factory	, office			28f. Location (Str. City or Town,		er or Rural	Route Number,
D	ital or A rs after ral Direc led in by								al.				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Expr	ysician: To the best niner: On the basis o	of my knowledge, dea f examination and/or in ated.	th occurred ivestigation.	at the tin , in my o	ne, date an pinion, dea	nd place, a ath occurr	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as sta ind due to	ated. the cause(s)
	To the living the To the I	Med	one) 29b. Signature and title of certifier	and manner st	ated.			e number			d. Date signed		
	T will		1	$_{T}\left(\right)$	ND			310	712		0/	2/200	
			30. Name and address of person who	completed cause of o			V -				110	100	/
	4+1		JULIO MENOUM, no		Possumzo	-	PIL	4 4	NED	ERILU	mD	217	20
	St	ate rar	31. Date filed (Month, Day, Year)		ar's Signature	4	1	,					

	1 = For State Registrer	State of Maryla	•	rtificate of			12004	31624
cian	Decedent's Name (First, Middle,	Last)				Date of Death Month	Day Year	3. Time of Death
ical	MILLIE	NELSON				September	21 2004	
er					r Location of Death		4c. County of Dea	
		JNITY HOSPITAL 6. Sex 7. Age (In vrs	In a 6 to look of a col		NHAM If Under 24 Hrs.	0 B (B) #	PRINCE GE	
	121-30-2334 Usual Residence of Decedent	1 M 2 M F 67	: last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 2	rear) Co	thplace (State or Forei puntry) ginia
	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limi
Director	MD Prince	George's	Landov	er				1 ☑ Yes 2 ☐ N
Ü	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
		d Street		20	785		U.S.A.	
Funera	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Drigin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2	1 Never Married 2 Marrie	d 1 □ Yes 2 🕱 No If Yes, Give		1 ☐ Yes 21 No			Specify:	0, 010.
		Year or Dates:						Black
1	15. Decedent' (Specify onfy highest		16a. Dece	dent's Usual Occup kind of work done	ation during most of works d)	ing 16	3b. Kind of Business	Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Service		I	OC Governm	nent
0 86	36 7 7	ast)			18. Mother's Name Jurean	e (First, Middle, Ma Early	aiden Sumame)	
	19a. Informant's Name/Relationsh	p (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number, C	City or Town, State, 2	Zip Code)
	Renita James/D	aughter	7201	E. Lomba	rd Street	Lanham,	Maryland	20785
	20a. Method of Disposition 1 1	3 □Removal from State	cemetery, crei	osition (Name of matory or other place	ce)		oc. Location - City or	
	21. Signature of Funeral Service L			Cemetery 2. Name and Addre	ss of Facility T		uitland,M ns Funera	
	X N No.	Lall					, Marylan	
	23a. Part1. Enter the disease, or o	omplications that caused the dea						Approximate
	shock, or heart faflure. List of Immediate Cause (Final disease or condition resulting in death)	_aM		ive .	Stroke			Interval Between Onset and Death 2 days
		Due to (or as a conse	quence or):	21 C	. /			N. OWERS
aminer	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	b. Due to for as a conse	quence of):	ar c	cienna			1007
-	resulting in death) Last	c. Due to (or as a conse	cuence of).					
a E		Due to (or as a conse	quence or,					
O		d						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3□	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deli	ivery Day Year
I A	Part II. Other significant condition	s contributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ted by		strige Re	nal	olis	eore	1 □ Yes	2□No 3□Pr	obably 4 Unknow
Completed		·				24a. Was an autopsy performe	d? prior to death?	topsy findings availab completion of cause of 2 No
Be		Hospital:		Oth	26. Place of Death	Check onl one		
P.		1 Inpatient 2L	ER/Outpatier 28b. Time or		4 Nursing Hor		e 6 Other (Spec	cify)
0	1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k?	28d. Describe how	injury occurred	
	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Bloom of Injury. At h	nome, farm, str		Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
rtifica	4 Homicide	3. , ,						
Certification:	4 Hornicide							
edical Certifica	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my kn xaminar: On the basis of examinand manner stated.	owledge, death	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)

State Registrar D050514

9/21/04

Suite 2100, RM, 20737,

olusia)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITY

MEHRU MASTER, MIX 6570 Kenilworth ave.

31. Date filed (Month, Day, Year)

SEP 2 2 2004

SEE 2 2004

For State Registra

1. Decedent's Name (First, Middle, Last)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29c. License number D0052075 September 16, 2004 14201 Laurel Park Dr., #221 Laurel, Maryland 20707 sacker

Reg. No.

3. Time of Death

4:13P.

10d, Inside City Limits

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

(unk)

Approximate Interval Between Onset and Death

Nigería

Black, White, etc.

Month

2. Date of Death

10

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1-person

Deep Kukreti, M.D.

31. Date filed (Month, Day, Year) SEP 21 2004

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DOS			For State Registrar		State of N	Maryland	•	artment of F rtificate of	Health and M <i>Death</i>	- '	giene Reg. No.	nnl	31626
	· ·		Decedent's Name							2. Date of Dea	ath		3. Time of Death
	Physici /Medic			Guadalup			oa			Septemb			0520 а м
	Examin		4a. Facility Name (If I Princess G				i11	4b. City, Town, o Lanham	r Location of Death			County of Death	orges
	Funeral Director		5. Social Security Nu. 393–23–01	mber 6. Se		Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	v, Year)	Cour	
			Usual Residence of D	Decedent						February	12,1		
	a-f show	ctor		Prince G	eorges		, Town or Lo ham	ocation				1	0d. Inside City Limits 1 ½Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6320 Hard		ve			10f. Zip Code 2070	06		-	zen of What Cour Jador	ntry?
9	after deal	Funer	11. Marital Status 1 Never Marrie	d 2⊡ Married	12. Was Deceder Armed Force 1 Yes 2	s?	5. 13.		Hispanic Origin? (Spean, Mexican, Puerto			14. Race - Americ Black, White,	
003	urel', c	d by	3 Widowed 4		If Yes, Give Year or Dates	s:				dorean			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event. It a Medical Examble or injury to other traumatic event. It a Medical Examble or injury to other traumatic event.	Completed	(Specif	15. Decedent's Edi y only highest grad dary (0-12)		or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire Entry	oation during most of worki d)	ing		nd of Business/Ind nputers	dustry
and 2	be filed value Hygie of other tevent.	Be	12 17. Father's Name (F Celso Ce	First, Middle, Last)			Data	caresy	18. Mother's Name		Maiden .		
Baltimore, Maryland	12 shoutd h and Mer 7 Is marku raumatic	P_C	19a. Informant's Nar Eduardo N	ne/Relationship (T					and Number or Rura ury Ridino				
ore,	ges 1 and t of Health If item 2: or other 1		20a. Method of Dispo			Ce	ace of Disponentery, cre	osition (Name of matory or other place) Recue	ce) Santa	per 25	20c. Lo	cation - City or To	
altim	ermit. Pa epartmen nportent: ny injury		`4 □Donation	on Other (Specify) Fral Service Licens)	rarc	2	2. Name and Addre	200	service			OI.
111	205 2		23a Barti Enter th	1,000	rcln_		P	O. Box	58007 Wash	nington,	$D_{\bullet}($	20037	Approximate
	Physician /Medical		shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only o final	a	ı lıne.	MUL		INJUM		1631,		Interval Between Onset and Death
	Examiner		Sequentially list con	ditions,	b			,					
	ecuted and -transit	aminer	Sequentially list con if any, leading to immoduse. Enter Underlicause (Disease or in that initiated events	nediate ying njury	Due to (or a	as a consequ	ence of):						
68760,	tificate be execul g physician and as the burial-trar	ũ	resulting in death) La	ıst	Due to (or a	as a consequ	ence of):						
687	rtificate ng phy: as the	Medic	15 55MALE		u								
D. Box	Attending Physicien: The law req. ires if at the death certificate be ex r death. ector: After this certificate has beer signed by the attending physician is by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 0	nonths?		2 □ Fetal at time of de	death 3	□Ectopic pregnanc	у		2	23d. Date of delive Month	ory Day Year
, P.O.	es if at thigned by	by Phy	Part II. Other signific	ant conditions co	ontributing to death	n but not resu	ılting in the u	Inderlying cause giv	ven in Part I.	23e. Did to	obacco u	se contribute to th	ne cause of death?
rds	w requires been sign should be									1 🗆 Y	es 2	ANo 3 □ Prob	ably 4 □Unknown
Division of Vital Records,	The law requite has been bage 2 should	Completed										prior to coi	psy findings available npletion of cause of 2 No
ital	iicien: Th certificate rector, pag	Be C	25. Was case referre						26. Place of Death	~		/-	
of V	Physic this co	2	1★ Yes 2 N	lo	Hospital: 1 Inpa		ER/Outpatie	III 3 DOA				Other (Specify occurred	at scene
ion	uttending I death. ctor: After y the funer	ation	1 Natural 2 Accident	5 Pending investigation	9/19/	ay Year)	Injury	Wo			CHC	OLLIDED	
Divis	al or Atte s after de il Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Hace of	Injury - At ho etc. (Specify) 1	PWAy		28 Location (S City or Tow	Street and vn, State)	Number or Rura	CIALDEN LIMITAM
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C				s of examinat	wiedge, dea	th occurred the ti	me, date and place, opinion, death occurr	and due to he	cause(s)	and manner as st	ated.
	To the within 2 To the comple	Me	29b. Signature and	ine of certifier	1 /1	n		29c. Licens				e signed (Month, tember 1	
((g) 1		30. Name and addre	//	completed cause of		23a) (Type	Print)	C!	D-74.		Mar-1-	nd 21201
	C1/02		MARY J	Ca. Miff	/	strar's Signat	ture	III Pe	nn Street	, Balti	iio <u>r</u> e	, магута	IN SIZUI
	Sta Regist		31. Date filed (MONII	SFP 2.1	2004	67		Soul .					

		State of Maryland / Dep	artment of Health and International Artificate of Death	Mental Hygier	2001	31627
		Decedenl's Name (First, Middle, Last)		2 Date of Death		3. Time of Death
Physicia /Medic		LEO T NICHOLS JR		Sept 19		5:15 A M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death	1
		College View Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederic	
Funeral Director		212-22-0830 1 XM 2 F 79 Yrs.	Months Days Hours Min.	(Month, Day, Yea		place (State or Foreign ntry) vland
		Usual Residence of Decedent				
arylan show	_	10a. State 10b. County 10c. City, Town or L Maryland Frederick Frederi			1	0d. Inside City Limits 1 ☐ Yes 21 No
he Ma	Director	10e. Street and Number	10f. Zip Code	100.0	Citizen of What Cour	
death with the Maryland ms 23e or 28e-1 show	늅	6351 Spring Ridge Parkway	21701	, og.	U.S.A	,
Jeath ms 23	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	can Indian,
or Ite		Armed Forces? 1 Never Married 2 Married IMYes 2 No IMYes Circle If Yes Circle If Yes Circle	1 ☐ Yes 2 ☐ No Specify:	o nican, etc.)	Black, White, Specify: Wh:	
72 hours after death with the Marylan 72 hours after death with the Marylan "neturel", or items 23e or 28e-1 show rulcal Examiner mast be mulified at	d by	3 Widowed 4 Divorced Year or Dates:	**	10		
n 72 t	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation In kind of work done during most of wor IDO NOT use retired)		, Kind of Business/Ind	dustry
within 7 iene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 1 2	ngineer	C	onstructio	on
be fited withintal Hygiene. Id other then	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	len Sumame)	
	To E	Leo Thomas Nichols, Sr.		rie Sprin		01701
of 2 should be fit to and Mental His marked off treumatic even			ing Address (Street and Number or Ru 51 Spring Ridge P		y or Town, State, Zip rederick,	
C = C4 F		20b. Place of Disposition	osition (Name of		Location - City or To	
Pages 'Pages' nent of H		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	ematory or other place)	t. 22, 200		
parmit. Pages 1 a Department of Hec Importent: If item eny injury or othe		1 - 1 - 1 - 1	2 Name and Address of Facility L. Molesworth			burg, Mu.
Per Per Per Per Per Per Per Per Per Per		Olin I Wolesworth 2	lin L. Molesworth 6401 Ridge Road,	P.A., Fun Damascus.	eral Home Marvland	20872-0117
PACOL, rate be executed whysician and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	LARROW DECOC	7	015018	Interval Between Onset and Death Onset and Dea
VISION OI VITAI RECOLUS, F.O. BOX 00/00, Attending Physicien: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
wrequires that the deben signed by the a	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	1.4
DIVISION OF VITAL RECORDS, at or Attending Physicien: The law requires taffer death. I Director: After this certificate has been signed in by the funeral director, page 2 should be at the page 2.	Completed			24a. Was an autopsy performed 1 ☐ Yes	prior to co death?	ppsy findings available impletion of cause of 2 \(\text{No} \)
ysicien: The ysicien: The is certificate he director, page	Be (25. Was case referred to medical examiner?	0.0	ath (Check only one)		
Physi Physi this c	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27 Manner of Death 28a. Date of Injury 28b. Time		tome 5 Residence		(5)
JIII ding F	lon	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	Edd. Bodonibe new ii	, all y december	
JIVISIO or Attendati after deati Director: in by the	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rura tate)	al Route Number,
Hospite 4 hours Funerel ely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dec 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier 11 game MO	29c. License number		Date signed (Month,	Day, Year)
8+1		30. Name and address of person who completed cause of death (Item 23a) (Type)	4 loans	M0 2	1716	
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 2 2004 32. Registrar's Signature	9 Sparks			

			For State Registrar		arylan		artment of F		d Mental Hy	giene Reg. No. 0	31628
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, L PAULINE EUGEN 4a. Facility Name (If not institution, gi	IA OLDEN		_	4b. City, Town, c	or Location of D	2. Date of De Month SEPTEMB	Day Y	3. Time of Death 2004 10:55
	Funeral Director		REEDERS MEMORIAI 5. Social Security Number 219-12-2022 Usual Residence of Decedent	Sex 7. Ag	је (In yrs. 39	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da		SHINGTON Birthplace (State or Foreign Country) MARYLAND
Je	with the Maryland a or 28a-f show	Director	10a. State 10b. County	NGTON	10c. Cit	y, Town or Lo		ONSBORO		10g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No at Country?
1-Jauliy	n 72 hours after death with the Maryla *netural', or Items 23a or 28a-f shov calcal Experient must be collided at	by Funeral	141 SOUTH MAIN S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2∑ No dent's Usual Occup	Specify:	? (Specify Yes or No uerto Rican, etc.)	U.S 14. Race- Black, Specify:	American Indian, White, etc. WHTTE
en 2121		Be Completed	(Specify only highest g Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Las	rade completed) College (1-4or	5+)	(Give	kind of work done OO NOT use retire	during most of d)	working Name (First, Middle,	CLOTHING	G MANUFACTURE
Name: 010 Baltimore, Maryland	ulth au 27 is r treu	To	HARRY W. SMITH 19a. Informant's Name/Relationship LORRAINE E. TAYL 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Prop. 2) 21. Signature of Furbral Service (Liv.)	OR/DAUGHTE	BO(18 DI Place of Disponentery, crer DNSBORO		BOONS	ELLEN GROS Rural Route Number BBORO MAF Date 23/2004	er, City or Town, Sta RYLAND 21 20c. Location - Cit	L713 y or Town, State
2 m	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listed of Figury that initiated events)	Pau1 mplications that causery one cause on each li a	d the deat ne. Lva a conseq	h. Do not ent Can uence of):	AST FUNER or the mode of dyir		Boonsbo	oro, Mary	
P.O. Box 68760,	ath certific titending p	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	of pregna	ancy	Ectopic pregnancy Other (specify)	у		23d. Date o Month	f delivery Day Year
	Iaw requires that the de nas been signed by the a a 2 should be detached f	Completed by P	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying cause grv	ven in Part I.	1 🗆 24a. Was autop	Yes 2 No 3	te to the cause of death? Probably 4 Unknown e autopsy findings available t to completion of cause of
Division of Vital Records,	ding Physician: The law h, After this certificate has funeral director, page 2 a	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury	28c, Injur Wor	ner: 4 Nursin	perfo 1 Yes Death (Check only of g Home 5 Resid	gane) dea 1□	th? Yes 2□ No
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ical Certification;	3 Suicide 6 Could not determine	be on Diese of In	of my kno	y) wledge death	eet, factory, office	me date and ni	City or Tov	vn, State)	or Rural Route Number,
•	To the twithin 24 To the F	Medical	29b. Signature and title of certifier 30. Name and address of person who	and manner st	ated.		29c. Licens	se number		29d. Date signed (A	
	Sta Regist		Dr. ROBERT GUE 31. Date filed (Month SEP) 3	DENET 21	MYZ	NDDRI	VE KEED	DYSVIL	LE, MD 2	1756 301	1-432-2222

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. E 20 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 20, 6:30 P 2004 Orrison September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 117 Easy Street Frederick Apt. 33 Thurmont If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 97 Yrs 218-30-9550 September 6,1907 Maryland Director Usual Residence of Decedent deeth with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinat must be rediffed at 1 Tyes 2 No Maryland Frederick Thurmont Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Easy Street 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ital any injury or other traumatic event, the Medical Evaluation. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Frederick News Agency Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oda Shafer Harry Orrison ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Orrison - wife 117 Easy Street, Thurmont, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/22/2004 Frederick Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Densee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician CY6775102 prostate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien at I for use as the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the and be detached for ☐Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has le 2 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 2 5 sesidence 6 □Other (Specify) this 28d. Describe how injury occurred i Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 Ept 21, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 146 21701 2040 501 Ca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Lener Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 22 2004 **Physician** 2:50 Ам ROBERT VINCENT PETERSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf 4028 Green Spring Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 12 1946 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **X**□ M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Washington, DC Director 217-44-7095 58 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other treumetic event, It e Madical Examiner hast be notified at 1 ☐ Yes 2 No Maryland Charles Waldorf Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA items 23a 4028 Green Spring Street 20601 Pages 1 and 2 should be filed within 72 hours after death in not of Health and Mental Hygiene. Int: If item 27 is marked other than "neturel", or Items 23 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes **2** ☐ No Yes, Give 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Givo Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Electric Business Material Handler 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Betty Richarson Bveedlove Vincent Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia E. Peterson (wife) 4028 Green Spring St Waldorf, MD 20601 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition rinity Mem Gardens ö 1X Buria 2 □ Cremation 3 □ Removal from State Waldorf, MD permit. Page Department of Importent: If any injury or once. 9 - 25 - 04on 5 Other (Specify) ¹ 4 ☐ Domati 22. Name and Address of Facility Eberwein Funeral Services 21. Signal r M00173 4433 White Pls. La. White Pls., MD 20695 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immorate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transil and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the hed t 1 ☐ Yes 2 ☐ No o 9 Unknown signed by the Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 Sidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: After Injury 1 Accident 5 Pending 1 Tyes 2 🗌 No death. investigation I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0052289 9/23/ 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nalin Mathur, MD 10 St Patricks Drive #404 Waldorf, MD 20603 32. Pagistrar's Signature 31 Date filed (Month, Day, Year) State SEP 2 3 2004 Registrar

			For State Registrar	State of Marylar		artment of H			giene Reg. No.	101.	31631
		10	Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	J (J -7	3. Time of Death
Ų.	Physicia /Medic		Lois	V.		Procto	ſ	09/19/	2004	Year	7:50 A M
-	Examin		4a. Facility Name (If not institution, give				Location of Death	1	1	ounty of Deat	h
	* *	7	Bradford Oak Nur				nton				eorge's
	Funeral		5. Social Security Number 6. Sec. 577–50–3321	THE WINE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)		hplace (State or Foreign nuntry)
ý-	Director		Usual Residence of Decedent	90				June 2	2, 19	14 Mis	sissippi
	ylanc how		10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits
	e Ma	ctor	Maryland Prince Ge	eorge's Ten	nple Hi	lls					1 ☐ Yes 2 🛱 No
	or 26	Director	10e. Street and Number			10f. Zip Code	20748			of What Co	untry?
	s 23c	eral	2512 Eliot Place	10 Wes Deceded Free is II	6 40				US		
	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.5. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puert	o Rican, etc.)	- 14.	Race - Ame Black, White	
93	urs af	by	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Sp	pecify: B1	ack
2	filed within 72 hours after death with the Maryland Hygiene. sther than "netural", or Items 23c or 28s-f ehow ent, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	ition	kina	16b. Kind	of Business/	Industry
7	athin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.	not use retired. 1 Teacher)		D C	C I	1.0.
7	iled w dygier ther ti	S	17. Father's Name (First, Middle, Last)	5+	Delloo	r reacher					1 System
anc	ould be fi Mental I- arked ot atic ever	Be c	Ivey Anderson				18. Mother's Nam				
2	should nd Men marke umatic	To	19a, Informant's Name/Relationship (7	vpe, Print)	19b. Mailir	ng Address (Street a	Ardell		lingsw er City or To		in Code)
<i>®</i>	and 2 sealth ar n 27 is		James C. Anderson/	'Nephew		5 Penning					.,,
ē,	ss 1 a of Heg item othe		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date		tion - City or	Town, State
Ē	Pages nent of I ant: If its ary or o		XIXBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State		1n Cemete		/04	Brent	wood.	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23c or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen			. Name and Addres			s Fune	eral H	ome PA
	90 E 9 9		Kart. Kar	as ()	6	160 Oxon	Hill Roa	d Oxon	Hill.	Maryl:	and 20745
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat one cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
ing.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ANTERWSC	lenti	hout	scary				Onset and Beating
	Examiner		1	Due to (or as a conseq	juence of):						
		e	if any, leading to immediate	b. Due to (or as a conseq	uence of):						
	uted d ansit	Examiner	Cause (Disease or injury	C							
Š	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):						
8760	cate be executed physician and the burial-transit	dlcal	(d							
٥	ertific ling p		IF FEMALE:	00. ((
Box	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	il death 3 □	Ectopic pregnancy			23d	. Date of deli- Month	very Day Year
o.	res that the de signed by the a be detached t	yslo	1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leaun 5L	Other (specify)					
٦	The law requires that the title has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Sp	quires n sigr							1 🗆 🗅	Yes 2□N	lo 3 Pro	bably *XXUnknown
Vital Records,	aw require s been si 2 should I	Completed						24a. Was		4b. Were au	topsy findings available
H	The lav	mo						autop perfo	rmed? 2XXNo	prior to c death? 1 Yes	ompletion of cause of 2 □ No
<u>E</u>	rysicien: Th	Bec	25. Was case referred to medical examiner?				26. Place of Deal			, , , , , ,	
	Attending Physicien: r death. ector: After this certific: by the funeral director,	ို	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐			XXXursing H	ome 5 Resid	dence 6	Other (Spec	ity)
n C	ding P. h. After 1 funera	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	now injury oc	curred	
Sic	Attend ar death ector: by the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ama farm at-		es 2□No	28f Location (6	Stroot and M	umba s a D	ra I Route Number.
Division of	l or Attendated after death	Certification:	4 Homicide determined	building, etc. (Specif		eet, ractory, office		City or Tow	vn, State)	uniber or Au	rai Aoute Number,
	e Hospital 24 hours a e Funerel I letely filled		29a. Certifier Certifying Phy	/sician: To the best of my kno	wledge, death	occurred at the tim	e, date and place,	and due to the	cause(s) and	d manner as	stated.
	To the Hospital or within 24 hours after To the Funerel Dirtembletely filled in I	edical	(Check only 2 Medicel Exam	iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my op	inion, death occur	red at the time,	date and pla	ce, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	-0		29c. License			29d. Date si	gned (Month	, Dey, Year)
_			may vion	5	, , , , , , , , , , , , , , , , , , , ,	235			Sept	July ?	10, 2004
R	- (15)		30. Name and address of person who c	completed cause of death (Iten	n 23a) (Type,	Print)	Roud C	Ent in	40)1	h 140	n
	Sta	te.	31. Date filed (Month, Day, Year)	2. Registrar's Signa	iture	roung m	- (a w		and have	الم مما	/
	Registr	13.	SEP 2 2 2004	Stew A	long	B					
DH	IMH 17 Bey 1/20	001		1	-						

DHMH 17 Rev 1/2001

			For State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me Certificate of Death			
7.2	17/4			Reg. N 2. Date of Death	-014	3. Time of Death
	Physici /Medic		HAN SOON PARK	Month D	ay Year	6:05 AM
>	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		c. County of Death	<u> </u>
			RANDOLPH HILL NURSING HOME WHEATEN		MONTGOR	NERY
	Funeral		7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. If Under 1 Year If Under 24 Hrs. If Under 24	8. Date of Birth (Month, Day, Yea	r) Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	5ULY 6,	1931 K	REA
	yland sow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar Hed	tor	MD MONTGOMERY COLLEGE PARK			1 Yes 2 □ No
	th the	ire	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Cou	ntry?
	23a	rai	3608 MARLBROUGH WAY 20740	Ĺ	I.S.A	
	er dez	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White	
36	rs afti	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: AS	AN/
Š	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show is Medical Everther must be inclifted at			16b.	Kind of Business/Ir	
215	hin 7.	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	9		,
7	ad wit giene er tha	Com	9 HOUSE WIFE	Į.	PRIVATE	
nd	be file tal Hy d oth sveni	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name ((First, Middle, Maide	n Sumame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic svent, it a Medical Ever trait must be indifficit	٦	NAM HEE YOU HEE S	OOK HA		
Ma	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Informant's Name/Relationship (Type, Print)	0.00		
	1 and Heall tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of Da	LoLLEGE 20c.	Location - City or T	20740 own State
ē	Pages nent of int: If it iry or o		Tabular 2 Dolemation 3 Diremoval from State	4/04 _		
Baltimore,	nit. Fortantine cortan		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHA	BER DR	VIDSON HINDS FULL	VERAL SERVICE
Ď	Dermi Depa Impo any le		12303 KRYAK DR. U			MD 20772
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on seeb line.	respiratory arrest,	ALDUAD	Approximate Interval Between
	Physician				ì	Onset and Death
	/Medical Examiner		resulting in death) Due/to (or as a consequence of):			
	Examiner	_	Immediate Cause (Final disease or condition resulting in death) a. Due/to (or as a consequence of): Sequentially list conditions, b. Higherman is Disease.	2		
	led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	xecu al-trai	Examiner	that initiated events c			
68760,	ificate be executed g physician and as the burial-transit	edicai I	C _d			
Вох	eath cer attendin for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	,
	e dea the att	Sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Month	Day Year
P. 0.	that the de led by the a detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	OO- Dida-b		
Š,	signed be det					he cause of death?
Records,	w requir been si should	etec				
Reć	The law cate has	Completed		24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of
Vital	ician: Th certificate rector, pag	e Co	07 West seed of the control of the co	1□Yes 2₽N		2 No
>	ysicia s cert direct	ToB	examiner?	e 5 Residence	6 Other (See	
0	g Phys ter this neral di	n: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	d. Describe how inju		7/
joi	endin sath. or: Af	atic	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of	after de Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	If. Location (Street a City or Town, Star		al Route Number,
	ospital of he urs at uneral Distilled i					
	1 4 E	Medical	29a. Certifier I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s I at the time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month,	Day, Year)
	r × F ŏ		1/ Warsed Xbu us 132812	Con	1	
1	3		30 me and address of p - son whompleted cause of death (Item 23a) (Type, Prigit	Sep	~~~	23,200g
1	54		Majeed that us pell George Me,	en but	in, a	0 00702
0	Sta		31. Date filed (Month, Day, Year) 32. Tegistrar's Signature			
	Registr	ar	SEP 2 3 2004 Been & April			

			1 - For State Registrar	State of Ma	-		ent of He ate of D		Mental H	ygiene Reg. No. 🤈	001.	21600
	Physici /Medic		 Decedent's Name (First, Middle, La Kendall Wayne Re 						2. Date of Dept.	Day	Year 2004	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution, given 275 Cassidy Whan 5. Social Security Number 6. \$2.21	f Road	(In yrs. last birtho	(ay) If Ur	Earlevi	.0cation of Dea .11e If Under 24 Hrs Hours Min	8. Date of E	Ceo	of Death Cil Co 9. Birthr	place (State or Foreign
	Director woy•	ō	221-66-5234 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location			Dec.20	0,1981		7er, DE 10d. Inside City Limits 1 □ Yes 2 ☑ No
	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelih and Mental Hyglene. Depertment of Heelih and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Item 200 and 20 and	ral Director	DE New C 10e. Street and Number 1159 Shallcross	Lake Road	Middle	10f.	Zip Code 19709			1	ed Sta	ntry?
0000	hours efter de urel', or item al Exemitation	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 □ Ye	s 2⊠ No	Specify:	Specify Yes or Note Rican, etc.)	Spec	ace - Americ lack, White, city: Whi	etc. Lte
-21717	ed within 72 i ygiene. her then "net it, the Medica	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 1 2	ade completed) Cotlege (1-4or 5-	(0)	ive kind of fe. DO NO	Technic	ring most of wo			st Con	
al ylallu	should be fill end Mental H e marked ott umetic even	To Be	17. Father's Name (First, Middle, Last Clarence D. Reed 19a. Informant's Name/Relationship (19b. N	lailing Addr		Charlo:	me (First, Middi tte Ann ural Route Num	Atkinso	n	Code)
E 'SIG	eges 1 end 2 ant of Heeith e it; if item 27 i		Charlotte A. Mil. 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removat from State	20b. Place of D cemetery,	sposition (Name of or other place)	arf Roa	Date	Earle 20c. Location	n - City or To	
Daltillor	permit. F Depertment Importar eny injur		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or com	1500		22. Name Spic 100(and Address cer-Mul N.DuP	of Facility likin I ont Pky	Funeral	Homes,I w Castl		
	Physician /Medical Examiner policy p	edical Examiner	shock, or heart faiture. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.	consequence of)		ih	esis				Interval Between Onset and Death
O. BOA 60	To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within £4 hours efter death. To the Funsel Director: Attenthis certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 ☐ Fetat death	3 □Ectopii 5 □ Other	c pregnancy (specify)				Date of delive	ory Day Year
CICS, T.	equires thet t sen signed by nould be dete	<u>a</u>	Part II. Other significant conditions (contributing to death bu	t not resulting in th	e underlyin	g cause given	in Part I.		tobacco use co		ne cause of death?
ומו חפכ	en: The law tificete hes b tor, pege 2 st	e Completed	25. Was case reterred to medical				2	26. Place of De	24a. Wa auto per 1 Yes ath (Check only	opsy formed? 2 No	o. Were autoporior to condeath?	psy findings available repletion of cause of 2 No
	nding Phyaici ath. r: After this cer ie funerel direc	atlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending Accident investigatio	Hospitat: 1 ☐ Inpatien 28a. Date of Injury (Month, Day)	/ 28b. Tim	e of	DOA Other: 28c. tnjury a Work?	4 Nursing t	lome 5 ☐ Res			Mother's hom
DIVISION	spital or Atta hours efter de nerel Directo filled in by th	al Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	(Specify) f my knowledge, d	eath occum	ed at the time,	date and place	City or To	own, State) cause(s) and r	nanner as st	I Route Number,
	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	niner: On the basis of and manner stat	examination and/o	r investigat	ion, in my opin 29c. License n	ion, death occi	urred at the time	29d. Date sign	, and due to	the cause(s)
	∫ [⊘] Sta	te	30. Name and appress of person who John Goodill, MD., 31. Date filed (Month, Day, Year)		sgow Ave	nue,N	ewark,			7	- 3/	
	Registr		3EF 23 2	UU4 Am.	K	break						

		1 - For State Registrar	State of Maryla		artment of Hea rtificate of De		ental Hygien Reg. N	0001	21.001.
		Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
Physic /Med		Ralph	Edward	Rua	ırk		Sept. 19.	ay Year 2004	9:33 AM ^M
Exam		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Lo			c. County of Death	
		1514 Riverside D	rive		Salisbur	У	1	Wicomico	
Funera	ı		Sex 7. Age (In y	rs. last birthday)	If Under 1 Year if Months Days	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9 Birth	place (State or Foreign
Directo	r	1/1-10-9/98	94	Yrs.			10-18-190		land
and w		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Maryl 1 ehc	ō	MD							1 Yes 2 No
the 28a-	Director	MD Wicor 10e. Street and Number	nico	Salisbu	10f. Zip Code		10g C	itizen of What Cou	ntov?
3a of		1514 Riverside I)rive		2180	1	103.0		, .
13-UU30 n 72 hours after death with the Maryland n 72 hours after death with the Maryland "natural", or Rems 23a or 28a-f show edical Examinar must be notilised at	Funeral	11. Marital Status	12. Was Decedent Ever in		Was Decedent of Hispa	anic Origin? (Spec	cify Yes or No-	USA 14. Race - Amen	can Indian,
within 72 hours after ene. then 'netural', or Ite	I.	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give		If Yes, specify Cuban, M		lican, etc.)	Black, White,	etc.
72 hours aff	1 by	3 Widowed 4 Divorced	Year or Dates:		TILITES ZEUNO S	Specify:		Specify: Whi	te
72 h	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual Occupation kind of work done during	n ng most of workin	g 16b. I	Kind of Business/In	dustry
d within giene. or then the Ma	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)				
D D D	ပိ	17. Father's Name (First, Middle, Las	none	Tru	ck Driver	Atothoda Nama	(First, Middle, Maide	ansportat	ion
ylaild buld be fill Mental Hy nrked oth	Be	Orlando M. Ruarl						n Sumame)	
should be nd Mental marked	10	19a. Informant's Name/Relationship		19h Mailir	Mi ng Address (Street and	amie Bai		as Town State 75	0-41
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic average.		Sterling E. Ruar	•						
Heal Heal	-	20a. Method of Disposition	201	. Place of Dispo	mithfield I sition (Name of natory or other place)	Lane Sui		iter, Flo ocation - City or To	
ages anf of t: If I		Burial 2 Cremation 3 (00.00			
DESCRIPTION Description of Appendix of App		21. Signature of Euneral Service Lice		22	d Cemetery Name and Address of	f Facility	-2004 Prin	ncess Ann	e, MD
Dep den you		awan A MI	MOO2	H	nman Funera	al Home			
		23a. Part1. Enter the III as , or con shock, or heart failure. List only	II I I I I I I I I I I I I I I I I I I		er the mode of dying, si	uch as cardiac or	respiratory arrest.		Approximate
Dhysiolog		Immediate Cause (Final	Cara	1 12					Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	a. Due to (or as a con-	eliac On	rest		 ,		MINT
Examine			Chran	a. GIM	outri He	out Fa	eline		VR5
	Je.	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):	rist gutur He tù Concli	, ,			1232
cuted ad ransif	Examiner	Cause (Disease or injury that initiated events	· Antei	vselent	in Concli	W userel	lor Lusie	elle	41.5
O, e exe an ar urial-t		resulting in death) Last	Due to (or as a cons	equence of):					
cate be executed physician and the burial-transif	dical		d						
		IF FEMALE:							
that the death certifed by the attending detached for use a	ician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre-	etal death 3	Ectopic pregnancy			23d. Date of delive	*
e de the a	sic	1 Yes 2 No	4 Pregnant at time of 9 Unknown	of death 5□	Other (specify)			MONUI	Day Year
requires that the	Physi	Part II. Other significant conditions	contributing to death but get	condition in the co		- Death	22a Didashaasa		
signe d be c	þ	Longed he	. //	esuiting in the ur	idenying cause given in	n Parti.	1 Yes 2	use contribute to the	
w requires that been signed the should be deta	eted	Carolina Star	Mary Congression				Tes 2	MENO 3 Pro	ably 4 Unknown
1 G " CI	ompieted	alsheimen	Lusean				24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
(0 0	Co	9					performed?	death?	2 No
ysician: Thysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	. Place of Death	Check only one)		
ਹ ਦੇ ਦ ੁਰ	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	☐ ER/Outpatien 28b. Time of			e 5 Residence		/)
Attending Physical Control of the Co	ertification:	1 QNatural 5 ☐ Pending	(Month, Day Year,	Injury	28c. Injury at Work? M 1 ☐ Yes	2 No	ld. Describe how inju	iry occurred	
VISION Attending er death. rector: Afte	fica	3 ☐ Suicide 6 ☐ Could not b	00 Diago of Injury A	home farm stre			If. Location (Street ar	nd Number or Rura	/ Route Number
pitel or Attenurs after deat eref Director:	erti	4 Homicide determined	building, etc. (Spe	icify)	out raciony, circo		City or Town, State	9)	rriodia rambar,
spite nours reref	a C	29a. Certifier 1 @ Certifying P	hysician: To the best of my l	nowledge, death	occurred at the time, d	date and place, an	id due to the cause/s	and manner as st	ated
To the Hospitel or Attendi within 24 hours after death. To the Furerel Director: A completely filled in by the fu	edical	one) Medical Exa	miner: On the basis of exam and manner stated.	nation and/or inv	estigation, in my opinio	on, death occurred	at the time, date an	d place, and due to	the cause(s)
To th withir To th	ž	29b. Signature and title of certifier	- /		29c. License nui	mber	29d. Da	ite signed (Month,	Day, Year)
		Shuld	M. home		010	688		9/20/04	•
		30. Name and address of person who		tem 23a) (Type, i	Print)			1-1	
		Burials M. 6	1000, 411	40 C	ASTON SH	ORE L	K106 5	quitage	1 his
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig						
Regis	-1-4	SEP 2 2	2004 Janen	, H.	Coul				
DHMH 17 Rev 1/	2001		3						

			For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	rtment of Heatificate of De		ntal Hygie Reg.	-200	31635
			Decedent's Name (First, Middle,	Last)			2	Date of Death		3. Time of Death
П	Physicia	_	CLARENCE	т	ROGERS	;		Month SEPT 15	Day Year 5 2004	9:04A M
>	/Medic Examin	V 35	4a. Facility Name (If not institution,	give street and number)	110000	4b. City, Town, or Lo			4c. County of Death	
	xamm		Prince George	Hospital		Cheverl	-V		Prince (George's
	Funeral	-		Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year		Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
E.	Director		235-48-1841	1 2 M 2□ F	73 Yrs.	Michael Suyo			1930 Ken	
	pu .	}	Usual Residence of Decedent 10a. State 10b. County		10c. City. Town or Lo	cation				10d, Inside City Limits
	shor	5		ce George'	7.	at Pleasa	ant			Yes 2□No
	he N	Director	10e. Street and Number	.c dedige	D DCC	10f. Zip Code		10a	. Citizen of What Cou	ntry?
	a or			11 Decle-			,	1.03		,
	eath	erai	112 Peppermi	12. Was Decedent	Ever in U.S. 13. V	20743 Was Decedent of Hisp		v Yes or No-	U.S.A.	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evacular must be notified at ance.	by Funeral	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2€€ If Yes, Give	Vo.	Nas Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 → No	Mexican, Puerto Ric Specify:	án, etc.)	Black, White,	
Maryland 21215-0036	hour:	Q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Deced	lent's Usual Occupation	20	161	b. Kind of Business/Ir	ndustry
7	n 72 n *na	Completed	(Specify only highest	grade completed)	(Give	kind of work done dur. DO NOT use retired)	ing most of working		harles C	
12	withi ene. than	шс	Elementary/Secondary (0-12)	College (1-4or 5	1.720.7	visor of	Fusic		ublic Sc	
0 0	filed withi Hygiene. other than		17. Father's Name (First, Middle, La		- Busca		8. Mother's Name (F		MANUAL DES	
an	d be ental ked c	To Be	John H Roger	^ S			Ocie	Harper		
2	should be and Mental s marked o umatic eve	-	19a. Informant's Name/Relationshi		19b. Mailir	ng Address (Street and	d Number or Rural F	Route Number, C.	ity or Town, State, Zij	Code)
Š	and 2 ealth a n 27 is		Ella Mae Roge	ers- Wife	112 1	Peppermil	ll Dr Se	at Plea	asant,MD	20743
Baltimore,	of Head	1	20a. Method of Disposition	_	20b. Place of Dispo	sition (Name of natory or other place)	Date	9 200	c. Location - City or T	own, State
Ë	Pages nent of I int: If it		1 ☐Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			Hill Cem	9/22	/2004	Suitland	, MD
ati	permit. Departm Importa any inju	1 8	21. Sig ature of Funeral Service A	censee	1 10 22	. Name and Address	of Facility Sno	wden F	uneral H	ome, P.A.
ä	Departiment of the permit of t	(Thomas K	, Duew	den:	246 N. Wa	ashingto	n St R	ockville	,MD20850
. 8 SE			23a. Part1. Enter the disease, or conscious shock, or heart failure. List o	omplications that caused	the death. Do not entine.	er the mode of dying,	such as cardiac or r	espiratory arrest,		Approximate Interval Between
VI.	Physician	i i	Immediate Cause (Final disease or condition	Colo		Heroscl	prosis		1	Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequence of):	140000				
E	Examiner		Sequentially list conditions	b						
	D ==	Iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
50,	ate be executed hysician and the burial-transit	Ü	resulting in odditry East	Due to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	Physician/Medical	_	d						
9	death certific e attending pl id for use as f	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of delik	
Вох	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Day Year
o.	the de	ysic	1 ☐ Yes 20☐ No 9 ☐ Unknown	9☐ Unknown	tuna or doutr	Curion (specify)				
Φ.	that ed b deta		Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	co use contribute to I	he cause of death!
Vital Records,	law requires as been sign 2 should be	d by						1 ☐ Yes	2 No 3 Pro	bably 4 Munknown
00	w require been si should t	Completed						24a. Was an	24b. Were auto	opsy findings available
Re	ø ← Ø	Ę						autopsy performed	prior to co	opsy findings available ompletion of cause of
a	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26. Place of Death (6	1 Yes 2	No 1 □ Yes	212 No
<u>=</u>	Physician: this certific ral director,	00	examiner?	Hospital: 1 ☐ Inpatie	ent all ER/Outpatier	Other			e 6 □Other (Speci	fv)
of		n: To	27. Manner of Death	28a. Date of Inju	iry 28b. Time of			d. Describe how		,,,
ion	Attending r death. actor: After by the fune	at lo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investiga		y Yeer) Injury		s 2 🗆 No			
Division	for Attendi after death. Director: A	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of my	jury - At home, farm, str c. (Specify)	eet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rur	al Route Number,
Ö	at or A s after al Dire	Cert	4 _ Homedo	building, et	c. (Opechy)		ļ	0.19 0. 701111, 0	, alo,	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (Physician To the best xaminer: On the basis o and manner st	of examination and/or in					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	//		29c. License n	number	29d.	Date signed (Month,	Dey, Year)
	->-0		> Te ale	16- n	~)	D-503	35	S	ept 16,	2004
	10		30. Name and address of person w	no completed cause of a	death (Item 23a) (Type.			<u>5</u>	DE 107	
	ı		/ 1/	Lucas, MD			Chever	V. MD	20785	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	/		-1111	<u> </u>	
	Regist		SEP 21	2004 Arms	was 13	sparker				

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of Herificate of L		•	giene		31636
	Physici	an	1. Decedent's Name (First, Middle, Las Dorothy Miles	Riley				2. Date of De	aath Day	Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution, give 94 North Hamill A	street and number)		4b. City, Town, or Bloomi		bepten	4c. Count	2004 y of Death rett	16:05 Рм
	Funeral Director			9x 7. Age □ M 2⊠F 8	e (In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	th ay, Year) 4 1916	Cour	olace (State or Foreign ntry) achusetts
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Worceste	er	10c. City, Town or Lo					1	0d. Inside City Limits 1 AYes 2 No
	3s or 28	i Direc	10e. Street and Number 1878 North Main S	St.		10f. Zip Code 01	522		10g. Citizen of United		•
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-1 show any injury or other traumetic event, it is Medical Examinational be notified at ance.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3CM/vidowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2004 If Yes, Give Year or Dates:	lo	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specity:	ecify Yes or No Rican, etc.)	- 14. Fla	ce - Americ	an Indian, etc.
21215-0036	J within 72 h piene. r then "netu ine Medical	Completed by	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5 2	(Give	dent's Usual Occupa kind of work done do DO NOT use retired) ral Direc	uring most of working	ng	16b. Kind of B		•
Maryland 2	ould be filed Mental Hyg arked othe atic evant,	To Be C	17. Father's Name (First, Middle, Last) Leon Kendric	k			18. Mother's Name Lulu	(First, Middle, Whee		ne)	
	and 2 shi salth and n 27 is m er traum		19a. Informant's Name/Relationship (7 Marci Capone/ ste		r 31 I	ng Address (Street at ndian Fall	nd Number or Rura Ls Rd., A	I Route Numbershville	er, City or Town,	State, Zip 28803	
Baltimore,	Pages 1: ment of He ant; If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Grove Ce	matory or other place metery	2004	4	20c. Location Holden,	MA.	wn, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licen	/// //	22	2. Name and Address 111 Church	of Facility Boa. 1 St., Wes	l Funer sternpo	ral Home ort, Mar	yland	l 21562
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (final disease or condition resulting in death)	a. NeAz	the death. Do not entire.	er the mode of dying	1	r respiratory a	rrest,	,	Approximate Interval Between Onset and Death
8760,	cate be executed obysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 68	The law requires that the death certifics ate has been signed by the attending pt page 2 should be deteched for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▷ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal déath 3 ☐	Ectopic pregnancy Other (specify)				te of delive	ry Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	~	nbute to the	e cause of death? ably 4 □Unknown
Il Records,	: The law requ cate has been page 2 shouli	Completed by						24a. Was autop perfo 1 🗆 Yes	rmed?	death?	sy findings available npletion of cause of 2 \square
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2□ER/Outpatien	Othor	26. Place of Death		ne) dence 6 □Oth	or (Canaita	
on of	ding Phy h. After thi funeral	tion; T	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day		28c. Injury Work?			now injury occur)
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	rry - At home, farm, str . (Specify)			8f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Diractory Completely filled in by	Medical	29a. Certifier Certifying Phyone) Check only one)	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	nd due to the o	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	· HA		29c. License	13 41 4		29d. Date signer		• '
			30. Name and address of person who o	1/2	eath (Item 23a) (Type,		10/ 1/24	1581 n	9/2 1, WU	21 - C	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2	- /	hp E94 ir's Signature	land a	7		I, WY	116	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Donald Reeves Francis 27, 2004 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 1 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/02/1919 Birthplace (State or Foreign Country) **Funeral** 85 YES Director 220-10-1202 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at MDDirector Allegany LaVale 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 398 National Highway 21502 Itеms 23e USA death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1∆ Yes 2 □ No 1943 -If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 'natural', or 1 ☐ Yes 2 No Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Engineer Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event <u>once.</u> Be Marion Francis Reeves Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary F. Reeves / son 398 National Highway, LaVale, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation ☐ Other (Specify) F. Cemetery | 09/30/2004 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, I.O.O.F. Cemetery 21. Signature Fune al Service Licensee 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gent myo cardis 24 hours /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Physician/Medicai the attending I 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the aid be detached to detached 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dinknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes 2 5 To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation м 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/IVA D21244 September 28, 2004

State Registrar 31. Date filed (Month, Day, Year) SEP 2 8 2004

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sports

Jesus H. Tan, M.D., 10701 New Georges Creek Rd, Suite 3, Frostburg, MD

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 2004 Edward Alva Ramsburg 18, September 6:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 123 Cresston Park Rd. Arnold Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. Yrs. Director 220-34-6734 67 11-12-1936 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Cresston Park Rd. 21012 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1954–62 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exameners once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs. Supervisor State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alva Sylvester Ramsburg, Sr. ٥ Laura Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann E. Cantrell/ Daughter 368 Long Meadow Way, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 9-20-04 * 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD 21. Signated of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home WHITE 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lancer -UNG yeak /Medical Due to (or as a counquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated event and resulting in death) Last Due to (or as a consequence of): the attending physician by Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ peudis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After s after dea. Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) ို 1 ☐ Yes 2 No 3□ DOA Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 atural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29c. License number

State Registrar

31. Date filed (Month, Day, Year)

STEPHEN

29b. Signature and title of certific

30. Name and address of person

m.D Lowinson egistrar's Signature

o complet aus of death (I am 3a) (Type, Print)

within 24 hours a To tha Funarai L

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 1 1 3 1 6 3 0											2 Q			
	Physicia	an	1. Decedent's Name (First, Middle, La	•	_							2. Date of Death Month Day Year			3. Time of [Death	
	/Medic	al	Viola	(a street and number)	7	T				September 19				1435	М		
	Examin	er	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					Ì	4c. County of Death				
	Funeral		Memorial Hospital 5. Social Security Number 6. Sex 7. Ag			last birthday)	Cumberland If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			24 Hrs. Min.	8. Date of Birt	h	Allegany 9. Birthplace (State of Country)			Foreign	
	Director		277-20-4471	1□M 20XF 7	7 2	Yrs.	MOHIT	Days	Hours	WIII I.	(Month, Da 09/23/	1931	-	Mary			
	land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10	Dd. Inside City	y Limits	
	Mary 1-f sh	tor	MD Alle	gany		Oldt	own								1 🗆 Yes	2 X No	
	th the	Director	10e. Street and Number										Citizen of What Country?				
	ath wi	rai	16700 Harves					215				USA					
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show spry injury or other traumatic svent, the Medical Examinat must be notified at ODGs.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:				**	spanic Orig n, Mexican Specify:	jin? (Spec , Puerto R	ify Yes or No- lican, etc.)			e - America k, White, e	atc.		
Maryland 21215-0036	n 72 hoi "natura edical i	Completed	15. Decedent's E (Specify only highest gi	ade completed)		16a. Deced (Give	kind of w	ua! Occupa rork done d use retired	luring most	of working	g	16b. Ki	Kind of Business/Industry				
212	d withing the state of the stat	omo	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker								Homemaker						
pu	al Hyg	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									1.1					
yla	Ment Ment Marke Marke	٩	William	Franklin	-	Robine				aulin		yne l			chley ————		
Mai	d 2 sh th and t7 Is n traum		19a. Informant's Name/Relationship								Route Numbe				Code)	- 17	
ē,	s 1 an f Heal itam 3		Barbara Landis / daughter P.O. Box 8, Sprin Gap, Maryland 21560 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition Date 20c. Location - City or Town, State												-		
Baltimore,	Page nent o int; If iry or		1 Description 3 Removal from State '4 Donation Community Of their (Specify) Mt. Tabor UMC Cem. 09/22/2004 Spring Gap, MD														
Salti	permit. Departn Imports eny inju		21. Signatur of Fureral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A.										P.A.				
ш	ZO = 5 0		Kebut C adome 404 Decatur Street, Cumberland, MD 21502											- 1			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death												een		
												6 days	,				
			Sequentially list conditions,	b													
		iner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
	death certificate be executed e attending physician and od for use as the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):														
8760,	siciar siciar e buri	dicai E	(d													
9	rtificat ng phy as th	Medi	IE EENALE.														
Вох	eath certific attending p I for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								2	23d. Date of delivery Month Day Year					
P.O.	the de	ysic															
	n requires that the de been signed by the s should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont									se contr	bute to the cause of death?				
ırds	en sig	ed b	Coronary Artery Disease								'es 2[3 ☐ Probably 4 🛣 Unknown					
ecc	law ri las be	Completed	Chronic Lu				autop	autopsv			Were autopsy findings available prior to completion of cause of						
al R	iclan: The law certificate has rector, page 2 :										performed? death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No						
Zi Zi	Physiclan: r this certific ral director,	o Be	examiner/								th (Check only one) ome 5 Residence 6 Other (Specify)						
Division of Vital Records	g Phy ler this neral d	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at								28d. Describe how injury occurred						
sior	Attending or death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	М		res 2 🗆 N	lo										
Ξ	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or 7									(Street and Number or Rural Route Number, Town, State)					
_	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											1			
	n 24 h n 24 h ha Fui	edicai	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinal	tion and/or inv	estigatio	n, in my op	pinion, deati	h occurred	at the time, o	date and	place, a	nd due to	the cause(s)		
		ž	29b. Signature and title of certifier					29c. License number					29d. Date signed (Month, Day, Year)				
•	5		Milin	2				. סכע	D36766 Sep					tember 20,2004			
	Des		30. Name and address of person who Vik Poonai					Cur	nher1	and	Maryla		2150				
	s Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa		-		nuel 1	, ii (i	патута	11.0	Z1)() _			
	Registr		SEP 2 1 2004	Serve	4	D,	000	chs									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 16, 2004 4:45 Ann H. Russ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 20, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days 75 Director 045-22-8977 1929 connecticut Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Director Texas Dallas Garl and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2948 Canis Circle 75042 United States Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if item 27 is marked other the any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Be Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Hornak Anna Belansky ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18th Avenue S.W. Dale Russ / Son 8620 Seattle, WA 98106 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 9/20/2004 14 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Baltimore, Maryland 21. Signature of Flundral Service Linksee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2110/0 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? Scleroderma 2 🗆 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification; To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation rector: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by ofter Direc 4 Homicide within 24 hours e To the Funerei I filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 24864 s of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

			For State Registrar	S	tate of Ma	arylan		artment rtificate			nd Mei	-	giene		316		
ı	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) 2. Date Mont									Date of Dea Month	of Death Day Year 3. Time of Death the Day Year cember 18 2004 8:30 M =				
	Examin		4a. Facility Name (If not institut	tion, give stre	et and number)					ocation of	Death			County of Dea			
	Funeral		1532 Lincol 5. Social Security Number	n Roa		e (In yrs. I	ast birthday,	Shad	1 Year	If Under 24	4 Hrs. 8.	Date of Birt	th.	ne Aru	thplace (State ountry)	or Foreign	
	Director		245-58-8205 Usual Residence of Decedent	1 (X M	2 F	67	Yrs.	Months	Days	Hours		(Month, Da ine 1		937 N.			
	arylan show	7	10a. State 10b. Coul	*		10c. City	, Town or L	ocation							10d. Inside	City Limits is 2 ☐ No	
336	be filed within 72 hours after death with the Maryland all Hygiene. I hygiene. I other than "naturel", or items 23a or 28a-f show other than "naturel", or items 23a or 28a-f show event, the Mcdical Examiner must be natified at	agy Agy	aryland Anne	Arun	del	Sha	dy S	ide 10f. Zip	Code				10g. Citi	zen of What C			
	h with 23a or 1st be	ai Di	1532 Lincol	n Roa	đ			20764						USA			
	r deal	Funeral	11. Marital Status			Was Decede	ent of His ify Cuban	panic Origi , Mexican,	n? (Specif Puerto Ric	y Yes or No an, etc.)	-	14. Race - American Indian, Black, White, etc.					
	irs afte	by Fi	1 ☐ Never Married 2 💆 M 3 ☐ Widowed 4 ☐ Divord		1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:		1 ☐ Yes 2	Specify:			Specify: B1						
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aryland	should be filed within nd Mental Hygiene marked other than armatic event, the Manatic event, the Manatic event, the Manatic event.	To Be	James	D. Sh	Shaw			Ressie				Haith					
lary	2 should and he is ma		19a. Informant's Name/Relation	onship (<i>Type</i> ,	Print)		19b. Mail	ing Address	(Street ar	nd Number	or Rural R	oute Numbe	er, City o	r Town, State,	Zip Code)		
e,	1 and Health Sm 27 ther tr		LaVerne Shaw 20a. Method of Disposition	(Wif	e)	20b. P		2 Lin		n Rd.	. Sha			Md.			
nor	Pages nent of h ant: If ite ury or o		Maurial 2 ☐ Crematic '4 ☐ Donation 5 ☐ Other		oval from State	Lak	emetery, cre	matory or ot H. Mem	ther place	a 1 🖟 0 .	/22/0			idsonv		Mđ.	
altimore,	コモモラ .		21. Signature of Funeral Serv			Gar	dens	2. Name and	d Address	of Facility	22,		241	1 45 511 0	11107	110.	
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A LINE	Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a	Due to (or as	142	M	iter the mode	e of dying	, such as c	ardiac or re	ANZI	rrest,		proxim Interval B onset an	etween	
ds, P.O. Box 68760,	ate be executed hysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
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	quires that in signed b	by	Part II. Other significant con-	ditions contributing to death but not resulting in the underlying cause given in Part I.								Did tobacco use contribute to the cause of de			f death? _Unknown		
I Record		Completed										24a. Was autor perfo 1 Yes		prior to death?	utopsy finding completion of s 2 \(\text{\subset}\) No	s available cause of	
n of Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to med examiner?		pital:		ED/0-1	20.00	Othe			Check only o		o (10th /0-	16.1		
	ding Physicien: h. After this certific funeral director,	\vdash	1 ☐ Yes 25 No 27. Manner of Death 15 Natural 5 ☐ Pe		28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)			of 2	nt 3 DOA 4 Nursing Home			5 A esidence 6 Other (Specify) d. Describe how injury occurred					
Division	deat deat ctor: y the	ertification:	2 Accident inv 3 Suicide 6 □ Co	estigation	be 380 Bloom of Injury. At home form street feature office							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	Hospite 4 hours Funerel ely filled	edical Co	29a. Certifier 1 Certifier (Check only one)	fying Physic cal Examine	ien: To the besi	of examina	wledge, dea	nvestigation,	at the time in my op	e, date and inion, death	place, and	due to the at the time,	cause(s)	and manner a place, and du	is stated. le to the cause	B(S)	
	To the within 2. To the complet	Med	29b. Signature and title of cer	tifier	and manner s	rated.	\wedge	290	. License	number	λ		29d. Da	e signed (Mon	oth, Day, Year,)	
)			Leto	NOS	SQ 30	M	1)	1	16	36	+		9	10010	4	4	
_			0. Name and ad it is sof	JUNE Y	DIETED CALL OF	death (Iter	23 in (Type	16H	JE /	1900	300	bur	SPAN	rus l	1094	5)	
	St Regist	ate	31. Date filed (Month, Day, Y	ear) 1. 20 04	32 Regist	trar's Signa	ature	Carll o									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Gilbert Strittmatter September 20 2004 10:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months **1** M 2 ☐ F **Director** 196-09-6590 Usual Residence of Decedent 2 1909 Pennsylvania with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23e or 28a-1 show the Medical Exampler must be notified at 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 dYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 178 Woods Drive 21403 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 **②** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: þ Specify 3 ₩Widowed 4 Divorced white Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 honn of Health and Mental Hygiene. ant: If Item 27 is marked other than "nati 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic automobiles traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Strittmatter Mathilda Sharbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Summerfield Dr. Annapolis MD 21403
ce of Disposition (Name of Date 20c. Location - Cit other Larry Strittmatter/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or tment * 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery Sept. 23, 2004 Annapolis, MD permit.
Departr
Imports
any inju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. romanos 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aediac /Medical Due to (or as a consequence of): Examiner 1760 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit certificate be executed and Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Yes 2 No 1 Yes Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Hospital or Attending P
 A hours after death.
 Funeral Director: After ti 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral (Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the Vithin 24 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ACUOPRA 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 2 1 2004

Aditya Chopra 621 Ridgely Avenue Suite 401, Annapolis, MD 21401

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 21,2000 September William Edmund Strebel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**∑**M 2□ F 82 **Director** 118-07-5283 FEB 25, 1922 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1√2 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 151 Southern Oak Dr. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married & Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 should be filed w h and Mental Hygier 7 Is marked other th 12 Industrial Engineer Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic swangs. George Strebel Alice Rousseau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel M. Strebel / wife 151 Southern Oak Dr. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | Sept.24 2004 Smithsburg Maryland 22. Name and Address of Facility Rest Haven 1601 Pennsylvania Ave 21. Signature of Funeral Service Licensee Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINUTES /Medical Due por as a consequence of): Examiner L arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation м 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature a 29c. License number P 29d. Date signed (Month, Day, Year) SEPTEMBER 23 2004 314-14 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 3248 Nagerstown Blash Maryland Steven Antietan 31. Date filed (Month SE, PY=2) 4 2004 32. P gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JOHNNIE, ROOSEVELT 16:15 M STEVENS JO 9 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND JOHNS HOPKINS - BAYVIEW BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12 M 2 ☐ F 49 578-78-8036 Yrs Director SOUTH CAROLI Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b, County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 10d. Inside City Limits 1 Tes 2 No Director andywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 0 -06/3 rashaw Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Prinkler 12 it of Health and Mental Hygie If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Ohnnie ROBSEVELT Stuens Rubinson Mac 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) te / 200. Location · City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place) Maynard undeld Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any injury or ott
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Com 25/04 Brentwood, 1110 ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee * Edwards 22. Name and Address of Facility Hoder es Silver Sintland me 20146 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician TOXIC EPIDERMAL NECROLYSIS 19 DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little of Jordan Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo ŧ 2 12 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and iddress of person who completed cause of deam (Item 23a) (Type, Print) WISBECK MD 4940 JALOB EASTERN M. AVE BALTIMOREND 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 6 2004

Registrar

			For	State of Maryland / De	epartment of Health and	Mental Hygie	ne	
			1 - State Registrar		Certificate of Death	Reg.	0001	31645
	Physic	ian	Decedent's Name (First, Middle, Las)	/	2. Date of Death		3. Time of Death
	/Med		Preston	Ocarbori	ough Jr.	Month /19 2	Day Yeer	8:30 AM
	Exami	ner	4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of De	ath	4c. County of Deet	
			Micready	Hospital	Cristield		Somer	set
	Funeral		5. Sociel Security Number / 6. Se	YM OBE D	Months Days Hours Mi		9. Birth	hplace (State or Foreign untry)
44	Director		Usuel Residence of Decedent	Am 20 P //2 Yrs	3.		31 1	18.
	land ow		10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	Man	ţō	MD. Some	set Maria	0.4			1 ☐Yes 2 ☐ No
	r 288	Director	10e. Street and Number	361 1/1/10/11	10f. Zip Code	100	Citizen of What Cou	/
	h will		5335 Tull'e (Orner Road	21858	log.	1 / C	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Amer	rican Indian
9	or Ite	F	1 Never Married 2 Married	TOTTES 2 No 1 100		erto Rican, etc.)	Black, White	etc.
21215-0036	72 hours after death with the Maryland natural', or Neme 23e or 28e-f show lical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: 1955	1 ☐ Yes 2 No Specify:		Specify: R	lack
7	nati	Completed	15. Decedent's Edu (Specify only highest grad		cedent's Usual Occupation ive kind of work done during most of w	ndring 16b	. Kind of Business/I	ndustry
12	within ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)		[]	. ~ 1
	Hygie ther t		17. Father's Name (First, Middle, Last)	Br	ushmakor	KI	Abberse	+ tactory
au	fental rked o	Be	Desert Co.	1 15	18. Mother's N	ame (First, Middle, Maid	en Sumame)	
Maryland	should and Me mark matic	2	19a. Informant's Name/Relationship (7)	Thorough or	· Juc	DIX		
Σ	od 2 s lith an 27 le		Annia Sand	196. Ma	ailing Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zi	p Code)
e)	1 an Heal tem 2		20a. Method of Disposition	20b. Place of Di	sposition (Name of		TION MI	151838
9	ages ant of t: If i		1 Burial Cremation 3 F	iemoval from State	crematory or other place)	200.	Location - City or T	own, State
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licens	11tiPe	22. Name and Address of Facility	5-04/M	arion!	nd,
B	Depa Impo any i		1 Dull	-tok	Serving South Ius	veral Home		
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death. Do not	enter the mode of dying, such as cardia	C.MOVE /	ns. 218	
	Physician		Immediate Cause (Final	e cause on each line.	1 0 1	A -		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Certiae 17mg	Minia		224 hours
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	ocute nd transi	Examiner	Cause (Disease or injury that initiated events	Drabet	23			7uers
90	Sian a	Ě	resulting in death) Last	Due to (or as a consequence of):				7
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			IF FEMALE:	N. M. S.				
Вох	death certif e attending d for use as	lan	in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3	B Ectopic pregnancy		23d. Date of delive	
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مــٰ	law requires that the as been signed by th 2 should be detache		Part II. Other significent conditions con	tributing to death but not resulting in the	underhine eases are in David	00. 5:44		
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	certificate	e Cc	25. Was case referred to medical			performed? 1 ☐ Yes 2 220	o death?	2 🗆 No
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0	ar this	-	27. Manner of Death	28a. Date of Injury 28b. Time		lome 5 Residence		/)
<u></u>	nding P ith. : After i e funera	i i	1 Swatural 5 Pending	(Month, Day Year) Injury		28d. Describe how inju	iry occurred	
Division	if or Attending Physician: after death. Director: After this certific d in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s		28f. Location (Street a	nd Number of Rum	(Co. to Must
<u> </u>	s afte	Cert	1 Hollicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Stat	e)	n Houle Number,
	hour hour ly fill		29a. Certifier Pertifying Phys	cian: To the best of my knowledge, dea er: On the basis of examination and/or i	ath occurred at the time, date and place	and due to the cause(s	and manner as st	ated
	in 24 in 24 the F	edical	one) 2 Medical Examin	er: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date an	d place, and due to	the cause(s)
i	I o the Hospital or within 24 hours after To the Funeral Direction Completely filled in D	Σ	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Mogth, L	Day, Year)
			- Hattelle 1	7	D1205326	2	19/24	1/04
			30. Name and podress of person who cor	ppleted cause of death (Item 23a) (Type	o, Print)		- 100	/
-				aker, MD	305 10-4 54.	Pocomoke	Citym	1.2/80
	Sta Registra	. •	31. Date filed (Month, Day, Year) SEP 2 4 7	32. Registrar's Signature	South .		-, -,	

			For Stata Registrar	State of Maryl	and / Dep	artme		lealth and	Mental Hyg	leg. No. 0 0 4	3 6 6
	Physicia	an l	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day Yea	3. Time of Death
	/Medic			Sesay						er 15, 20	
	Examin	er	4a. Facility Name (If not institution, give s	·		1		r Location of Dea	th	4c. County of D	
			Washington Adventi		en land hiethele.	+	koma	If Under 24 Hrs	10.0	Montgom	
	Funeral Director		5. Social Security Number 218-15-0156 Usual Residence of Decedent	7. Age (III)	rrs. last birthday Yrs.	Mont		Hours Min		, Year)	Birthplace (State or Foreign Country) erra Leone, WA
	land ow	_	10a. State 10b. County		City, Town or L	ocation					10d. Inside City Limits
	the Man 28s-f sh cuiffied	Director	MD Montgome	ry S	ilver S		g Zip Code			On Cirina di Ma	1 X Yes 2 □ No
	with a or	ā							'	U.S.A.	Country
	leath	era	2800 Wiseman Rd	12. Was Decedent Ever i	n U.S. 13		20902	lispanic Origin? (9	Specify Yes or No.		merican Indian,
320	I within 72 hours after death with the Maryland liene. Ithen "naturel", or Items 23a or 28a-f show the Madical Examinat must be notified at the Madical Examination.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			pecify Cuba s 2□XNo	Specify:	Specify Yes or No- to Rican, etc.)	Black, W Specify: B	hite, etc.
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2	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mail	ing Addr	ess (Street	and Number or R	ural Route Number	r, City or Town, State	e, Zip Code)
	od 2 lith a 27 is		Amadu Sesay-Top/F	lusband	2800	Wis	eman	Road Sil	ver Spri	ng, Maryla	and 20902
ค์	s 1 and 2 f Health Item 27 othar tra		20a. Method of Disposition	20	b. Place of Disp cemetery, cre	osition (Name of			20c. Location - City	
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.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3		pregnancy (specify)			23d. Date of o	delivery Day Year
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0	Physician: this certific al director,	ို	1 1 162 2 X 100		ER/Outpatie	nt 3 🗆	DOA Oth	4 Nursing F	lome 5 Reside	ence 6 Other (S)	pecify)
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Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, larm, st ecity)	reet, fact	ory, office		28f. Location (St City or Town		Rural Route Number,
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	vithin 2 To the complet	ž	29b. Signature and title of certifier			1	29c. Licenso	e number	2	9d. Date signed (Mo	onth, Day, Year)
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(ge		30. Name and address of person who co	· ·			DE		DDTIIC 35		
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			1 - For State Registrar	State of Maryla		artment rtificate			nd Me		jiene eg. No.	004	316	8
	Physici /Medic	cal	Decedent's Name (First, Middle, Lass Spencer Roy Saser As Facility Name (If not institution, give	berg		4h Cih. T	· · · · · · · · · · · · · · · · · · ·	anning of l	S	2. Date of Dea Month eptemb	Day er 1	4 2004	3. Time 6	M
t	Examin	ier	NAval Institutes	s of Health		Beth	nesda				Mo	County of Deat		
	Funeral Director		5. Social Security Number 6. S 348-50-8727 Usual Residence of Decedent	ex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day 11 09	Year) 55	L Co	hplace (State buntry) essee	or Foreign
	death with the Maryland ms 23a or 28a-f show r must be multified at	tor	10a. State 10b. County		ity, Town or Lo	cation	-						10d. Inside (City Limits
	or 28a	Director	TN 10e. Street and Number	W.	hiting	10f. Zip (Code			1	0g. Citiz	zen of What Co	untry?	
	be filed within 72 hours after death with the Marylan table Hygiene. d other than "netural", or liems 23a or 28a-f show event, the Marital Examinat must be confilled at	by Funeral	1703 Robert Ave: 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	nue #3 12. Was Decedent Ever in to Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1			panic Origir Mexican, f	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	Ì	SA 4. Race - Ame Black, White Specify: Whi	e, etc.	
215-0036	within 72 hou lene. than "neture the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Decec (Give life. I	dent's Usuai kind of work DO NOT use	Occupati done du retired)	ion ring most o	f working		16b. Kir	nd of Business/	Industry	
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saltimore,	Pages 1 and of He not: If Item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, crem [etropo	natory or oth	e of ner place)	1	Dat -21-0			ation - City or		
Balti	permit. Pages Department of Importent: If It any injury or o		21. Signature of Funeral Service Licen	hall's	Fun	eral Ho	ome	-						
	ate be executed /Medical Examiner the burial-transit	Examiner	23a. Party Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	andary quence of): (Oal quence of):	t	151	such as ca	,	espiratory arr			Approxima Interval Be Onset and WILK	tween
Box 68/60	ate the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	al death 3	Ectopic pre					2:	3d. Date of deli		Year
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Vital Records,	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Completed	hemorrhagi	e cystitis					_	24a. Was a autops	y ned?	24b. Were au prior to death?	ompletion of	available
		Be	25. Was case referred to medical examiner?	No acida (s			-		Death (1 ✓ Yes 2 Check only on	e)	1 ☑Yes	2 No	
ion of	sing Phy n. After this funeral d	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury a Work?	4 IAUISI	280	5 ☐ Reside		Other (Spec	eity)	
Division	To the Hospital or Attendii within 24 hours after death. Yo the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, etc. (Spec	ify)					City or Towr	, State)	Number or Ru		nber,
	ne Hosp 24 hou ne Funei deteky fil	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at vestigation, i	t the time, n my opin	, date and p nion, death	olace, and occurred	d due to the ca at the time, da	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)
	within (C)	Ž (29b. Signature and title of certifier	th S Hug	the			102			9d. Date	signed (Month	Day, Year)	
	IC.		30. Name and address of person who		m/23a) (Type, Center		e, Be	etheso	da, N	Marylan	ıd 20	0894		
	Sta Registr		SEP 2 3 2004	32. Registrar's Sign	ature									

Sharin Suvanasai Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar 04 - 6140AKG Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 8:20 PM SHARIN SUVANASAI September 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Davs Hours 25 Director 218-19-0384 May 19, 1979 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Prince George's Mount Rainier 10f. Zip Code 10g. Citizen of What Country? with 5 Itams 23a 3604 Perry Street 20712 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturat", or Itams 23s any injury or other traumatic event. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Thai þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Environmental Elementary/Secondary (0-12) College (1-4or 5+) Computer Science/Microbiologist Science 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chatree Suvanasai Michelle Sust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Sust - Mother 3604 Perry Street, Mount Rainier, Maryland 20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 9/30/04 |Metropolitan Crematory | Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 allace 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Cyanide poisoning /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if you cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran The law requires that the death certificate ba exacu Due to (or as a consequence of) P.O. Box 68760, physician ian/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Physici 5 ☐ Other (specify) 9 Unknown þ signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1/2 Yes 2 | No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Yes 2□ No 2 1√3 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 1 Natural 5 Pending after death. 1 ☐ Yes 2 No 2 Accident investigation 9-21-04 Subject ingested cyanide the 6 Could not be determined 3 X Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nymber or Ryral Route Number, City or Town, State) 3604 Perry St., within 24 hours a To the Funeral D Mt. Ranier, MD Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only only 29b. Signatur title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 24, 2004 pleted cause of death (Item 23a) (Type, Print) M 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature OCT 0 1 2004 Registrar

1 State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			- Hegistrar				7016	meate of	Dealii		F	leg. No:			
	Physici		Decedent's Name ALMA		RAY	SHIRLE	Y				Date of Dea Month EPTEMBI	Day	Yea 14 200	r	:30 P M
	/Medic Examin	_	4a. Facility Name (If I					4b. City. Town, o	r Location of Dea		<u> </u>		County of De		• 50 1
	E X d I I I I I	EI	PRINCE G	-					VERLY					EORGE	15
	Funanat	Art	5. Social Security Nu			(In yrs. last birth	day)	If Under 1 Year		i. 8	. Date of Birtl	h			State or Foreign
	Funeral Director		237-76-00 Usual Residence of D	15	□M 2KRE	55 Yr		Months Days	Hours Min		(Month, Day	/, Year)		Country)	arolina
	and			10b. County		10c. City, Town	or Loca	ation						10d. Ins	ide City Limits
	death with the Maryland ms 23s or 28s-f show fault by notified at	ŏ	MD	Prince	George's			onhill							Yes 2□No
	28a-	Director	10e. Street and Numi		occipe 5			10f. Zip Code				10- 0'1-	4 14 15 - 4	2 1 2	
	with				venue # 104			20745				U.S.	en of What	Country	
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	itan Itan	Funeral	11. Marital Status 1 ☐ Never Marrie	d 200 Married	Armed Forces?		13. W	Yes, specify Cubi	lispanic Origin? (9 an, Mexican, Puer	to Ric	can, etc.)	' '	Black, W		iari,
0000	irs af	by	3 Widowed 4		If Yes, Give Year or Dates:		1 [☐ Yes 2X No	Specify:			5	Specify:	Black	
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512	n n	piet	(Specif	y only highest gra	ide completed)		Give ki	ind of work done O NOT use retire	during most of wo	rking		100. 14.	a 51 5 4 5 11 10	ow moustry	
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	Elementary/Second	th	College (1-4or 5			ptionist				Pr	ivate		
3	Hyg othe	a)	17. Father's Name (F	First, Middle, Last,	1			-	18. Mother's Na	me (l	First, Middle,	Maiden S	iumame)		
2	ld be enta kad ic ev	To B	Mark We	st Speig	ht				Pessie I	Lee	Pende	r			
=	Shou mar mar	-	19a. Informant's Nar	πe/Relationship (Type, Print)	19b. N	Mailing	Address (Street	and Number or R	ural F	Route Numbe	r, City or	Town, State	, Zip Code)	
Ě	nd 2 lith a 27 is r tra		Melvin R	. Shirle	y/Husband	110	6 M	Montello	Ave NE	Was	shingto	on. D	C 200	02	
Ď	Hes Hem Hem othe		20a. Method of Dispo) / 114654114	20b. Place of D	isposi	ition (Name of		Dat				or Town, St	ate
Dallimor	age ent o st: #		1 X Burial 2 ☐		Removal from State			atory or other plac Gordon C	em. 10/	02	/2004 1	Wiiso	on. No	orth C	arolina
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4,			23a. Part1. Enter the	e disease, or com	plications that caused one cause on each lir	the death. Do no	t enter	r the mode of dyir	ng, such as cardia	c or r	espiratory an	rest.		Appro	ximate
	ALL		shock, or heart Immediate Cause (F											Interv	al Between and Death
	Physician /Medical		disease or condition resulting in death)	-	a ARTERI	a consequence of	27	K GNI	Jours Cu	169	N DI	Jea	se	40	ans
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	nsit	nin	Sequentially list conditions if any, leading to immorause. Enter Underl Cause (Disease or in	ying njury											
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ם	deat e att		in the past 12 m 1 Tes 2		4∐Pregnant at	time of death	5 🗆 (Other (specify) _	/ 				Month	Day	Year
5	law requires that the death as been signed by the atter 2 should be detached for t	Physici	9 Unknown		9□ Unknown										
,	ns tha	by P	Part II. Other signific	cant conditions	contributing to death be	ut not resulting in t	ne und	derlying cause giv	ren in Part I.		23e. Did to	bacco us	e contribute	to the caus	e of death?
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5	g Phys er this eral di		27. Manner of Death		28a. Date of Injui (Month, Day		ne of	28c. Injur Wor			d. Describe h			Jecny)	
0	nding Path. r: After e funer	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigation		Year) Inju	iry		'k? Yes 2⊡No						
DIVISION	el or Attending F s after death. I Director: After d in by the funer	ertification:	3 Suicide	6 Could not b	289. Place of Inju	ıry - At home, fam	, stree	et, factory, office		281	Location (S	treet and	Number or	Rural Route	Number,
5	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Sert	4 Homicide		building, etc	c. (Specify)					City or Tow	n, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	aic	29a. Certifier	1 Certifying Ph	ysician: To the best	of my knowledge,	death (occurred at the tir	ne, date and place	e, and	d due to the c	ause(s) a	nd manner	as stated.	
	Me Ho	edical	(Check only one)	≥ Medical Exar	niner: On the basis of and manner sta	examination and/	or inve	estigation, in my o	pinion, death occi	urred	at the time, d	late and p	lace, and d	ue to the ca	use(s)
	the the	Me	29b. Signature and t	itle of certifier				29c. Licens	e number		2	29d. Date	signed (Ma	nth, Day, Ye	ear)
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			For State Registrar	State of Maryla		rtment of F		Mental H	ygien Reg. No	2001	31651
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	Physici /Medic		SUSAN		S	KLUT				16,200	
3	Examin Funeral Director	er	4a. Facility Name (If not institution, give 100 / 5. Social Security Number 214-58-2757 1	Epkins Ho:	Spital rs. last birthday) 53 Yrs.	4b. City, Town, of Bay 14 If Under 1 Year Months Days	or Location of Deat MOCE If Under 24 Hrs Hours Min.	8. Date of B	olrth Day, Year		ath Inhplace (State or Foreign country) Shington, DC
	D D		Usual Residence of Decedent					- July		LJJI Was	,
	ehow	J.	10a. State 10b. County		City, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 💆 No
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	with Ba or					2085	_			itizen of What C	•
	ms 2:	Funerai	7237 Millcrest Ter	12. Was Decedent Ever in	1 U.S. 13. W		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N		ted Stat	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, its Medical Exertiest must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 21 No	an, Mexican, Puerl Specify:	o Rican, etc.)		Black, Whi	·
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Maryland	d be finds I be of	Be					18. Mother's Nar	•		- 1	
Ž	should tind Ment	스	Abraham Jose 19a. Informant's Name/Relationship (7)		19b. Mailing	Address (Street	and Number or Ru	rian Rac			Zin Code)
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Baltimore,	of Health itam 27 othar tra		20a. Method of Disposition	20t	p. Place of Dispos cemetery, crem			Date 04	-	ocation - City or	
E O	perrit. Pages: Department of H Important: If its any injury or ot		1 ⊕Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Inditional tions State	ıdean Mer			19/04	01r	ney, MD	
alt:	Departm Departm Importa any inju		21. Signature of Fu veral Septice Licen		22.	Name and Addre	ss of Facility				
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	eath. Do not ente	r the mode of dyir	ng, such as cardia	or respiratory	arrest,	, DC	Approximate Interval Between
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	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2□Fe 4□Pregnant at time o		Ectopic pregnancy Other (<i>specify</i>)	/			Month	Day Year
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ion o	fter		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injun World M 1	yat k? Yes 2 ∐No	28d. Describe	how inju	ry occurred	
Division	To the Hospital or Attandl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stre ecify)	et, factory, office			(Street ar own, State		ura i Route Number,
	he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	ysician: To the best of my k niner: On the basis of exami and manner stated.	knowledge, death ination and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s , date and) and manner as d place, and due	s stated. e to the cause(s)
	To the within To the complex c	Ň	29b. Signature and title of certifier			29c. License	e number		29d. Da	te signed (Mont	h, Day, Year)
}	COC			charl Venst.			-000		Sept	ember 1	6,2004
	(6)		30, Mame and address of person who o								
			Jeffrey Michael Venst 31. Date filed (Month, Day, Year)	norn Johns Hyok	ms Hospita			et Baltir	nore	marylan	1 21287
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	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las HUBERT 4a. Facility Name (If not institution, give	LEE STEWA	ARD Si	4b. City, Town, or	Location of E	2. Date of De Month Sept Death	15, 20	Year 3. Time of Death 9 0 4 8:00 AMM by of Death
	Funeral Director		237-46-3602		last birthday) Yrs.	Mitche If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir	th	nce George 9. Birthplace (State or Foreign Country) N. Carolina
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3-003e	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f show he Modical Exactiner aust be notified al	d by Funerai Director	19700 Lake Ar. 11. Marital Status 1 Never Married Ar. 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	? (Specify Yes or No Puerto Rican, etc.)	5- 14. Ra Bla Speci	Black
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Maryland 2121	2 should be f and Mental I is marked or sumatic evs	To Be	Edward Stewer 19a. Informant's Name/Relationship	Type, Print)			Ma and Number o	ry E. M	IC Dona	ald n, State 20 777)]
ballillore, IV	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If tram 27 is marked othar than "natural; or Itams 23a or 28a-1 show any injury or othar traumatic evant, the Modical Examinating must be inclined at once.		Yvonne T. Stew 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21 Ignature of Funeral States	Removal from State MC	Place of Dispondentery, cres	osition (Name of matory or other place onal Pa. Name and Addres	rk 9/	Date 21/04	20c. Location Laurel	•
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	sate be executed why sician and the burial-transit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. METASTAT Due to (or as a consequence of the con	uence of):	NCEATIC	CANCE	ER .		
r.O. box o	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	ldeath 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
ָר (SB)	w requires that been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death but not res	-	nderlying cause give	n in Part I.			ntribute to the cause of death? 3 ☐ Probably 4 ⊠Unknown
		e Completed	25. Was case referred to medical				26 Place of	24a. Was autor performance 1 Yes	psy prmed? 2 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2X No
DIVISION OF VITAR	ding Phys	To B	examiner? 1 Yes X No 27. Manner of Death 1X Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	at Nursia	ng Home \$ Residence 28d. Describe		
	pital or Atteno burs after death aral Diractor: illed in by the	i Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specif	(y)	,	a data and a	City or Tov	wn, State)	ber or Rural Route Number,
		Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my op	inion, death o	occurred at the time,	date and place,	and due to the cause(s) ed (Month, Day, Year)
	Sta Registr		30. Name and address of person who Dr. Adrain Hu 31. Date filed (Month, Day, Year) SEP 2 1 20		21 Me	Print)	e Ln l		•	, MD 20774

				State of Maryland						egibic.			
		4	For State Registrar	State of Waryland		tificate of D			eg. No	004	31653		
			Decedent's Name (First, Middle, Last)		-			2. Date of Deat Month	h Day	Yeer	3. Time of Death		
	Physicia /Medic		Charles W. Sykes	s, Sr.				Sont.	14	2004	1:55 pm		
)	Examin	er	4a. Fecility Neme (If not institution, give s			4b. City, Town, or				County of Death	_		
- 100 - 100	Funeral	Ara .	Prince George Hos 5. Social Security Number 6. Sex	Spital 7. Age (In yrs. last	t birthday)	Chever1	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign		
	Director		242-16-5761	M 2□F 84	Yrs.	Months Days	Hours Min.	June 12	, 19	20 Nor	th Carolina		
	pud *		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Lo	cation					10d. Inside City Limits		
	Maryli f sho	Į.	MD Prince Ge	eorge's Rive	erdal	e					Y☐Yes 2☐No		
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citiz	en of What Cou	untry?		
	23a c		6805 Ingraham Stre			20737				ed Stat			
	items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 		Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	1	 Race - Amer Black, White Δ f : 			
35	urs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	I□Yes 24 No	Specify:			Specify: .	rican		
Ž Ž	within 72 hours after death with the Marylan lien. The Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation 1	(Give	lent's Usual Occupa	uring most of wor	king	16b. Kin	d of Business/l	ndustry		
2	ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired) ding Oper			Ent	reprene	our		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)		v C11			ne (First, Middle, I					
<u>a</u>	should be nd Mental nmarked c	To Be	William O'Berry	Sykes			Gertrud	e Wynn					
ary	01 00 00 00	П	19a. Informant's Name/Relationship (Type			g Address (Street a				Town, State, Z.	ip Code)		
ຊົ ໜົ	1 and 1 Health Iom 27		Charles W. Sykes, 20a. Method of Disposition			Ingraham				20737 ation - City or 1	Fown State		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti		1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State		sition (Name of natory or other place ek Cemete				ington			
	artme ortani injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funera) Service License			. Name and Addres							
ñ	permit. Departimport Import		Indré Il	Dupson	7	400 Georg	ia Ave.	N.W., Wa	shin		ton, D.C. 20012		
ill in			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death		
0.716	Physician	96 U	Immediate Cause (Final disease or condition resulting in death)	Acute		rocardie	1 Inta	retion			Minutes		
Æ	/Medical Examiner		1	Due to (or as a consequent							01446		
₽ģ.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	nce of):		Δ Δ				13/441		
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	Gast	pointestiv	id Hs	emonto	g.P		DAYS		
60,	te be executed ysician and te burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequen	nce or):				•				
687	ficate physics the	edica	d										
Box (The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	230. was decedent pregnant	3c. If yes, outcome of pregnancy		Ectopic pregnancy			2	3d. Date of deli	•		
о П	that the death cer ed by the attendin detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of deat		Other (specify)				Month	Day Year		
P. O.	hat the		9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resulting	ng in the u	nderlying cause give	on in Part I.	23e. Did tol	bacco us	se contribute to	the cause of death?		
ds,	uires tha signed ild be del	d by	Demention					1 □ Ye	es 🦖	√o 3□Pro	obably 4 Unknown		
OS	law requir as been si 2 should	Completed	Coronary	Artery Dig	and a			24a. Was a		24b. Were au	topsy findings available completion of cause of		
Re	The la ate ha	No.						autops perform	ned?.	death?	S		
Division of Vital Records,	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	acnital:		Otho		ith (Check only on	(8)				
_	Physi rthis o	2	1 ☐ Yes 2 No		VOutpation 8b. Time of		4 Nursing H	lome 5 Reside			ify)		
on	th. : After	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □No						
VIS	f or Attending Physician: after death. Director: After this certifical in by the funeral director, I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town		Number or Ru	ral Route Number,		
	urs aft ral Di									1			
	Hospital 24 hours of Funeral stely filled	Medical	29a. Certifier 120 Certifying Physical Check only 2 Medical Examination (Check only one)	sician: To the best of my knowledger: On the basis of examination and manner stated.	edge, death n and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	r, and due to the ca arred at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date	signed (Month	n, Day, Year)		
	iL		> K. Muhaes	Jun		000	52865		Se	stense	18 2004		
	4		30. Name and address of person who co				01		′				
	- 0		Michael Figaro,	4.D. 3001 Hos 32. Registrar's Signatur		l Drive,		, MD 20	785				
	St: Regist		SFP 2 1 201	14 Depender	19	books							

			1 - For State Registrar	State of N	Maryland /		artmen <i>tificat</i>			nd M	lental Hy	/giene	() L ₁	31654
	Dhusia		1. Decedent's Name (First, Mid	ldle, Last)							2. Date of D Month	eath Day	V	3. Time of Death
	Physic /Medi		Franklin	Shifflett,	Jr.						Sept.	20,	2004	15:01 M
	Exami		4a. Facility Name (If not institut	ion, give street and numbe	ər)		4b. City,	Town, or	Location of	Death		4c. Co	unty of Death	
			Shady Grove A					kvil				Мо	ntgome	ry
	Funeral		5. Social Security Number 219-52-1409	6. Sex 7 1 □XM 2 □ F	Age (In yrs. last i 53		If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Year)	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	1 - A		Yrs.					May 13			ryland
	land		10a. State 10b. Coun	ty	10c. City, To	wn or Loc	cation						1	0d. Inside City Limits
	Marylan f show	ō	Manzzland Mana											1 ☐ Yes 2 X No
	the 288	Je C	Maryland Mont 10e. Street and Number	gomery	Damas	scus	10f. Zip	Code				10a Citizen	of What Coun	itn/?
	3a or	a	27920 Ridge	Road			1	2087	2			-		iuy.
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jisel Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. V				in? (Spe	ocify Yes or N	U. S	Race - Americ	an Indian.
9	after or Ite		1 ☐ Never Married 2 🛣 Ma	Armed Force arried 1 ☐ Yes 2 [Puerto :	ecify Yes or N Rican, etc.)		Black, White,	
8	ral', c	þ	3 ☐ Widowed 4 ☐ Divorce	ed If Yes, Give Year or Date:	s:	1	☐ Yes 2	2LX No	Specify:			Spe	ecity: Wh	nite
5-0	72 hours natural', ulcul Ex	Completed	15. Decede	ent's Education rest grade completed)	16	a. Deced	ent's Usua	l Occupa	tion uring most o	of worki	na	16b. Kind o	of Business/Inc	dustry
21	d within giene. rr than "	n Jdu	Elementary/Secondary (0-12)		or 5+)	life. D	OO NOT us	e retired)	uning most	JI WOIKI	ilg			
2			12			C1	Lerk						Market	t
and	0 0 0	Be	17. Father's Name (First, Middle								(First, Middle		name)	
ž	should be ind Mental marked o	၉		ifflett, Sr.							у Мае			
Maryland 21215-0036	CA 60		19a. Informant's Name/Relation Marilyn Y. Sl								Cus, M		wn, State, Zip	Code)
	is 1 and of Health item 27 other to	- 6	20a. Method of Disposition	TITTIECT - W						-				
Baltimore,			1 XBurial 2 Cremation		20b. Place cemet	ery, crem	atory or ot	her place)		ate		on - City or To	
Ξį	그 돈 뿐 글		'4 □Donation 5 □Other		Montg									Maryland
Bal	Dermi Depa Impo any ir		21. Signature of Emeral Service	e Licensee	(1)	0 ²² :	Name and	Addres: Mo L	of Facility eswor	th E	P.A., F	uneral	Home	0872-0117
8760,	Examiner Chysician and physician and the burial-transit the burial-transit the burial-transit than the properties of th	I Examiner	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence	of):	de g	Sh	plu n es	ly of	arl Ha	cau	Rana	Interval Between Onset and Death
P.O. Box 6	death certifi e attending I id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant 9□Unknown	2 Fetal deat at time of death	5 🗆	Ectopic pre	ecify)	in Part I		23a Did t			y Day Year e cause of death?
ords,	requires sen sign nould be	ted by								_ ;		Yes 2□No		1/
Vital Record	a SC	Completed										osy rened?	prior to com death?	sy findings available pletion of cause of
ita	ian: rtifica tor, p	0	25. Was case referred to medic	al					26 Place of	f Death	1 ☐ Yes	22 No	1 ☐ Yes 2	ZI No
_	ysic is ce direc	To B	examiner?	Hospital:	tient 2 ER/O	utpatient	3 DOA	Other					Other (Specify)	
ion of	Attending Physician: r death. ector: After this certifici by the funeral director.		27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28a. Date of In (Month, D		Time of Injury	28 M	c. Injury : Work?	at	2	8d. Describe t			
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 6 ☐ Could	mined 286. Place of It	njury - At home, f etc. <i>(Specify)</i>	arm, stree	et, factory,	office		2	8f. Location (S City or Tox	Street and Nui vn, State)	mber or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical C	29a. Certifier (Check only 2 Medica	ing/Physician: To the bes I Examiner: On the basis and manner s	or examination	e, death o	occurred a estigation, i	t the time	, date and p nion, death	occurre	nd due to the d	cause(s) and date and place	manner as sta e, and due to t	ted. he cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifi				29c.	License	number	-		29d, Date sin	ned (Month, Da	av Xear)
)	⊢≯⊢ŏ			1			18	01	LG/	11	7		9/	20011
		1	20 Name and adding 1		D - 11 - 11	-	^		10		l	6	· XI.	MILT
	10		30. Name and address of page	ctor Witten, Will Castroenterology	0 = 1 1 -			ente	r Driv	7e	Suite	308 Ro	ckville	,MD20850
	Sta	te	31. Date filed (Month, Day, Year		trar's Signature				- DII	,	JULLE	500 , KU	CVATTTE	الد الد الد الد الد الد الد الد الد الد
	Registr		SEP 2	2 2004	neva	4	1	20						

		1 - State Registra Amend #10b & 1	State of Maryla L Oc,9-22-0 4	nd/De¦ 4 pe n€	partment of l	lealth and Mo Death		jiene leg. No.?	91655
Physici /Medic		Decedent's Name (First, Middle, Last)	Smusvn				2. Date of Dea Month Septemb	Day Ye	3. Time of Death
Examir		4a. Facility Name (If not institution, give stra Gilchrist Hospice	0		4b. City, Town, o	or Location of Death	<u>Deptemb</u>	4c. County of D	Death
Funeral Director		5. Social Security Number 6. Sex 1欠 M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs	. last birthda Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day) Feb. 10		Birthplace (State or Foreign Country)
death with the Maryland ms 23a or 28a-f show	tor	10a. State 10b. County Worceste Maryland Worcheste	r		City	- A - 1 T			10d. Inside City Limits 1 □ Yes 2 □ No
ith with the Maryla 23a or 28a-f shov	Director	10e. Street and Number 9500 Costal Highway		JU COS	10f. Zip Code	ay Apt. iJ		Og. Citizen of Wha	t Country?
or ita	by Funeral		Was Decedent Ever in I Armed Forces? 1 DYes 2 DNo If Yes, Give Year or Dates:1944.		21842 B. Was Decedent of Fif Yes, specify Cub 1 Yes 2 No	dispanic Origin? (Specan, Mexican, Puerto R		Black, V Specify:	American Indian, Vhite, etc.
d within 72 hours giene. ir than "natural", ibe Medical Exis	Completed	15. Decedent's Educat (Specify only highest grade c Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	16a. Dec (Giv life.	. DO NOT use retire	pation during most of working d)		16b. Kind of Busine	
d be filed v ental Hygie cad othar t c avant, th	To Be Co	17. Father's Name (First, Middle, Last) Nicholas Smusyn	5+	Engi	neer	18. Mother's Name Josephine	(First, Middle, I	Communica Maiden Sumame)	ation Company
if Health and Mental Hygitam 27 is marked other other traumatic avant.	Ĕ	19a. Informant's Name/Relationship (Type. Laurie Anna Gilkenso	*			and Number or Rural Road Sil	Route Number		
y or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 1 ☐ Donation 5 ☐ Other (Specify)	oval from State	Place of Disp cemetery, cr	position (Name of ematory or other plac	Da	mber	20c. Location - City Odenton,	or Town, State
Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	014		22. Name and Addre	ss of Facility	n Servi	ce P.O.	
mysician /Medical Examiner		23a. Part1. Enter the dispase, or complicate shock, or heart failure. List only one disease or condition resulting in death)	ions that caused the dea cause on each line.	ith. Do not e 入力と(nter the mode of dyin	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	Due to (or as a conse	quence of):					
g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conse	quence of):					
as been signed by the attending phys 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
been signed b should be deta		Part II. Other significant conditions contrit	outing to death but not re	sulting in the	underlying cause giv	en in Part I.			e to the cause of death? Probably 4 hknown
ate h page	Completed					· · · · · · · · · · · · · · · · · · ·	24a. Was ar autopsy perform 1 Yes 2	y prior	
44 hours after death. Funaral Director: After this certificate tely filled in by the funeral director, pag	atlon: To Be	2 Accident investigation	oital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time Injury	of 28c. Injur	vat 28	e 5 Reside		ingureed pecify Hospica
rrs after deatl ral Diractor: lled in by the	Certification:	4 Homicide	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town	, State)	Rural Route Number,
within 24 hours after deat To tha Funaral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physici (Check only one) 2 ☐ Medicel Exeminer 2	en: To the best of my kni On the basis of examinand manner stated.	owledge, dea ation and/or i	th occurred at the tin nvestigation, in my of 29c. License	pinion, death occurred	at the time, da	te and place, and o	due to the cause(s)
within 2 To the complete		David De			BBE	168303		18/04	mui, vay, rearj
Sta	to.	DAVID BEKEIMA 31. Date filed (Month Day, Year)		6601	N. Chi	ARles St	· Tow	son, Mb	21204
Registr		31. Date filed (Mooth Day, Year) SEP 2 2 2004	32 Registrar's Sign	b. A	rest				

DHMH 17 Rev 1/2001

4/10/04

		1 - For State Registrar	State of	Marylan		artmen rtificate			and M	lental Hy	/giene		31656	
	sician edical	Decedent's Name (First, Middle, Last	Margaret	Bell Sh	ockey					2. Date of Do Month Septe	Day ember 2	2, 2004	8:15P N	И
Exa	miner	4a. Facility Name (If not institution, given 1430)						Location C				County of De	Ilegany	
Fune Direct	_	5. Social Security Number 214-28-6678 1 Usual Residence of Decedent	9X 7. □ M 2 5 F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi (Month, D. September	rth ay, Year) er 12, 19	9. B	irthplace (State or Foreig Country) Maryland	n
Maryland a-f show	ctor	10a. State 10b. County	gany	10c. Cit	y, Town or Lo	ecation	L	onacoi	ning				10d. Inside City Limit:	
uth with the 23a or 28	ral Director		stown Stree	t		10f. Zip	Code	21539)		10g. Citi	zen of What (Country?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examine trust be notified at	d by Funeral	3 Widowed 4 □Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? No		Was Deced f Yes, spec 1 ☐ Yes 2	200	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	nerican Indian, lite, etc. White	
Maryland 21215-0036 to 2 should be filed within 72 hours aff tilth and Mental Hygiene. 27 Is marked other than "natural, or traumatic event, the Medicel Event.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	16a. Dece (Give life.	dent's Usual kind of won DO NOT us	k done di e retired)	urina most		ng	16b. Kii	Nursi	s/Industry ng Home	
aryland should be file and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) Ror	ald Thomas	Nicol						(First, Middle				
e, Mar 1 and 2 sh 1 ealth and 3 m 27 Is m		19a. Informant's Name/Relationship (7 William Nicol	Brother	20h B	19b. Mailir		14300		Drive S	Route Numb S.W., Cum	berland	,Md. 2150)2	
Baltimore, permit. Pages 1 ar mportant: If item mportant: If item iny injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen)		emetery, cren Cumbe	rland Cr	emator	ry	2	eptember 27, 2004		cation - City o Cumberlar	nd, Maryland	
Balti permit. Departi	OUC	23a Part. Enter the disease, or control to the or board failures.	Ĺ	ed the death	E		McKer	nzie Fun	eral H			in St.,Lon	aconing,Md.21539)
death certificate be executed WW earthcomply strain and wind-transit or use as the burial-transit	a a a a a a a a a a a a a a a a a a a	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, large leaves. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or.	as a consequ	usince off):	0659	truc	tive	lung	e dise.	ase		Interval Between Onset and Death	
P.O. Box 68 that the death certifice ed by the attending pt detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1⊡Live birth 4⊡Pregnant 9⊡ Unknowr	2 Fetal at time of de	death 3	Ectopic pre Other (spe					2	3d. Date of de Month	elivery Day Year	
യ് ഒ ഉ		Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the un	derlying car	use giver	in Part I.					o the cause of death?	1
of Vital Reco Physician: The law re r this certificate has be- inal director, page 2 sho	e Completed	25. Was case referred to medical								1□ Yes	rmed? 2 12 No	24b. Were as prior to death?	utopsy findings available completion of cause of 2 2 No	_
Division of Vital Records, P.O or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	ation; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir		ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 🗆 Nurs	sing Hom	(Check only o e 5 □ Resid 8d. Describe h	dence 6.		acity Brother fairle	22
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To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	sician: To the bearing and manner	or examinati	vledge, death ion and/or inv	estigation, ii	n my opir	nion, death	place, ar occurred	d at the time, o	date and p	lace, and due	e to the cause(s)	
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3 LS	24	30. Name and address of person who come address of person who come and address of person who come and address of person who come address of person who come and address of person who come add	1IN 48	Tarn	23a) (Type, F	Print)	Fos	1Bur	g 1	MD Z	153	2		
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			1- For State of Maryland / Dep State of Maryland / Dep	artment of Health and Mertificate of Death	, ,	0001 01777						
			Decedent's Name (First, Middle, Last)	Tuncate of Beatif	2. Date of Death	3. Time of Death						
Н	Physici		ANNA THELMA MOLINARI THOMPS	SON	Month SEPTEMBER	Day Year						
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
Н			ALLEGANY NURSING & REHAB. CENTER	CUMBERLAND		ALLEGANY						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)						
	Director		220-10-2535 Sual Residence of Decedent			1915 MARYLAND						
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits						
	Many First	ģ	MD ALLEGANY CUMBER	RLAND		XXYes 2 □ No						
	h the	Director	10e. Street and Number	10f, Zip Code	10g	J. Citizen of What Country?						
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	r dea	Funerail	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: WHITE						
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ha Madical Examihar must be malified at	ed t		dent's Usual Occupation	1.00	WIIIIE						
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Maryland	01 00 00 00			ng Address (Street and Number or Rural BOX 93 - RIDG								
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			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest	Approximate Interval Between Onset and Death						
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П	/Medical Examiner		resulting in death) Due to (or as a con equence of):	ADCT		10 /						
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Вох	leath certitic attending p	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delivery						
o.	The law requires that the death certitic ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	1 ☐ Yes DE No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month Day Year						
Ω.	res that the de igned by the a be detached t	h h	Part II Other significant conditions contributing to feath but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?						
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Re	ician: The la certiticate has rector, page 2	Completed		d.	autopsy performed	prior to completion of cause of death?						
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Sio	Mtendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be 280 Block of Injury At home form the	M 1 Yes 2 No								
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	To the Hospitel or Attending Physician: The inwithin 24 hours alter death. To the Funerel Director: Atter this certiticate ha completely tilled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	occurred at the time, date and place, an	d due to the cause	e(s) and manner as stated.						
	the H nin 24 the F nplete	Medical	one) and manner stated.		at the time, date	and place, and due to the cause(s)						
		2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)						
	3		VIT- Rayllhan	117/30		xpt. 24,2004						
,	nes		30. Name and address of person who completed cause of death (Item 23a) (Type, I) (INANISO LANG	Mr	191500						
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ Chivideles 100		31000						
	Registr	_	SEP 2 7 2004 Can by	park								

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:00 PM PHILIP 2004 ADAMS THOMPSON 09 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNAPOLIS ANNE ARUNDEL HFART HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1X M 2 F Yrs OHIO Director 224-22-6738 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Ves 2 No Directo MD ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 1001 TIMBER CREEK DR. U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: MARINES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be titled within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite, rry or other traumatic avant, the Medical Examina. 1 ☐ Never Married 2 ☐ Married U.S. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT GENERAL ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be **THOMPSON** GRACE ADAMS 2 ACORS R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PEGGY THOMPSON/SPOUSE 1001 TIMBER CREEK DR., ANNAPOLIS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 09/16/04 SALISBURY CREMATORY SALISBURY, MARYLAND 22. Name and Address of Facility WILLIAMS FUNERAL HOME 21. Signature of Funeral Service Licensee John J. Wellams 94 MARKET ST. ONANCOCK, VA 23417 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on dech line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 y121 **Physician** CORONARI DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown EMENTIA, DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an performed? 1 ☐ Yes 2 XNo or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Moursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24768 9115/04 m Walch 30. Name and address of person who completed cause of death (Ipon 23a) (Type, Print) 作N. FARM RD. 277 , ARNOUD, MI) RM DABBS, WMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Elen & Sparke

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 PER FH C836 16/PCsificate Inf Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Eleanor Traiger September 14, 2004 1857 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Director May 4, 74 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10h Counts permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural, or Items 23a or 28e-f show any injury g-other traumatic event, the Medical Examinat must be notified at once. 10a State 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince Georges Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5501 Winston St 20778 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Harry Salawitch Lillian Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyman Traiger/Husband 6111 Montrose Rd, #615, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) King David Memorial |Sept 19, 2004 Falls Church, VA 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIOSC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 3 No Yes the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 R/Outpatient 2 1 🗌 Yes 2 🖳 No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 27. Manner of Death 1 Autural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) LINE CONTEL WALDENF, Md. ZOGOZ WISOMU 12070 daso-31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 20,2004 3:30 A Edith E. Wilner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Respite Home at South Haven Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 31,1912 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Hours Min. Director 92 England 207-24-1678 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 236 2553 Golfers Ridge Rd. 21401 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Ward Nellie Whitehouse 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i 2553 Golfers Ridge Rd., Annapolis, MD 21401
pate 20c. Location - City or Town, State Norman S. Wilner/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H importent: If ite any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-20-04 Kalas Crematory Edgewater, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee Mula 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANCREATIC 2mounts disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Juisease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): ding physician Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown O. detached is been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) RUIPIE Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 ther (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Home After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours at To the Funerel D To the Hospitei 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title d 16364 30. Name and address of person of death (Item 23a) (Type, Print) (0415 (IW ELTGRAWNA ODE GREGATTES) 31. Date filed (Month, Da State Registrar

				For State Registrar	iate of Maryland / De	epartment of H Dertificate of L		ai Hygiei Reg.	2001.	31661
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				NORTH ARUNDEL HOSE 5. Social Security Number 6. Sex			BURNIE If Under 24 Hrs. 8, Dai		ANNE ARU	
		Funeral Director		225-50-3251 Usual Residence of Decedent	7. Age (In yrs. last birtho	Months Dave	Hours Min. (Mo	te of Birth onth, Day, Ye 22 19	ar) 9. Birth Cou 40 Virg	place (State or Foreign intry) inia
		aryland show	_	10a. State 10b. County	10c. City, Town o					10d. Inside City Limits
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Δĺ.	;	th with 23a or	ai Di	6510 Blacklog Stree	et	20743			U.S.A.	my :
PALMA	936	s I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. He fleam 21 is marked other then "naturel; or Items 23a or 28a-f show other treumatic event, if a Medical Ever it at mast be rutilised at	by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. Armed Forces? ☐ Yes 2 ☑ No f Yes, Give fear or Dates:	13. Was Decedent of Hi If Yes, specify Cubal 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yen, Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - Ameri Black, White, Specify:	, etc.
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D)	nd 2	al Hygi I other vent, I	Be C	17. Father's Name (First, Middle, Last)	<u> </u>	gistered	18. Mother's Name (First,	Middle, Maid		
alker	Maryland	Ment Ment narked natice	To		ore		Rosa B.	Parkl		207/2
3	Ma			19a. Informant's Name/Relationship (Type, Marchie J. Williamson	1/Son 120	lailing Address (Street a	ind Number or Rural Route	Number, Cit Capita	y or Town, State, Zi; al Heights	, _{Code} ,20743 s, Maryland
t.	nore,	ages 1 and nt of Health t: If item 27 / or other tr		20a. Method of Disposition 1 Remo	Val IIOIII State	isposition (Name of crematory or other place	1		Location - City or To	
100	Baltimore	permit. Pages Department of Importent: If i eny injury or once.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Harmon	22. Name and Address		Jenki	ndover,Mai ns Funera	1 Home
7		10 2 0 U		23a. Part1. Enter the disease, or complication	ons that caused the death. Do not		over Road La		, Marylan	Approximate
		Physician /Medical Examiner		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	- head	2 rnei			Interval Between Onset and Death
			ulner	Sequentially list conditions, b. — if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of).	1				
	68760,	rificate be executed ng physician and as the burial-transit	edicai Examiner	that initiated events ccccc	Due to (or as a consequence of):					
	P.O. Box 6	Physicien: The law fequires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as:	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ary Day Year
	rds, P	w requires that been signed b should be deta	b	Part II. Other significant conditions contribu	ting to death but not resulting in th	e underlying cause give	n in Part I. 23		use contribute to the	
	Division of Vital Records,	icten: The law recertificate has be ector, page 2 sho	Completed					a. Was an autopsy performed? Yes 2	24b. Were auto prior to cor death? 1 ☐ Yes	psy findings available mptetion of cause of 2 No
	Vit	ysicien is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospi	tal: 1 Inpatient 2 □ ER/Outpa	itient 3 DOA Other	26. Place of Death (Check 4 Nursing Home 5		6 MOther (Canait	
	ion of	ottending Phydeath. ctor: After thi y the funeral		27. Manner of Death 1 Astural 5 Pending 2 Accident investigation	Ba. I te of Injury 28b. Tim Injury Injury	e of 28c. Injury Work	at 28d. De	scribe how in		7
	Divis	al or Atteness after death	Certification:	3 Suicide 6 Could not be determined 28	Be. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. Loc City	ation (Street a or Town, Sta	and Number or Rura te)	l Route Number,
		To the Hospital or Atlending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical C	(Oneck only Ze Medical Examiner:	n: To the best of my knowledge, do On the basis of examination and/o and manner stated.	eath occurred at the time r investigation, in my opi	e, date and place, and due nion, death occurred at the	to the cause(time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
	, ;	To th comp	Me	29b. Signature and title of certifier		29c. License	number	29d. D	ate signed (Month, I	Day, Year)
	13	3/0		Hate	mo,	124	3977	Seg	tember à	11 2004.
	C	ALC.		70. Name and a dress of person who comple	ted cause of death (Item 20a) (Tyl	Deve,	In Brun	me.	mp	zmbl =
	•	Sta Registr		SEP 2 3 2004	32. Registrar's Signature	1				400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ORIGINAL

			State	e of Maryland /				ental Hygier	•	
			For State Registrar	,		te of Dea		Reg. J	5 0 m 1	31663
	Physici	20	Decedent's Name (First, Middle, Last)				2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Joe Wright				5	ENTEMBER	221200	04 3; 00° W
	Examin	er	4a. Facility Name (If not institution, giv) street and			Town, or Locat			4c. County of Dea	
	Funeral		St. Thomas More Nursin 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Unde			B. Date of Birth (Month, Day, Yea	rince Ge	rthplace (State or Foreign
	Director		250-42-1628 ^{1X M 2 □}	F 73	Yrs. Months	Days Hou	urs Min.	7/16/31	Sa]	uda, S.C.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location					10d. Inside City Limits
	Maryl -f sho lled a	to	D C	17-	oper Mar	lhoro				1 AYes 2 □ No
	th the	Director	Md. P.G. 10e. Street and Number			p Code		10g. (Citizen of What C	Country?
	ath wi	ral	1905 Crack Willow Co			20774			U.S.A.	
	ler de Itams Inarr	une	Arme	Decedent Ever in U.S. of Forces?	13. Was Dece If Yes, spi	dent of Hispanio ecify Cuban, Mex	c Origin? (Speci kican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
920	urs at	by F	3 ☐ Widowed 4 ☐ Divorced Year	/es 2 □ No. s, Give 50 – 152 or Dates:	1 ☐ Yes	2€ No Spe	cify:		Specify: E	Black
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Examinar must be notified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade comple		a. Decedent's Usi (Give kind of w	ork done during	most of working	16b.	Kind of Business	s/Industry
121	within	mp	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	life. DO NOT	use retired)				J .
	be tiled tal Hygie d other t		10th 17. Father's Name (First, Middle, Last)		Maintena		other's Name (First, Middle, Maid	rivate I _{en Sumame)}	naustry
<u>lan</u>	ould be Mental Marked c	To Be	Joe Wright				Ada Cul	breth		
Maryland	2 shot and N is ma		19a. Informant's Name/Relationship (Type, Print,					Route Number, City		Zip Code)
	is 1 and 3 Health item 27 other tr		Laura Ann Wright /Sis		100 Pine of Disposition (Na		Luda, S.		B Location - City or	r Town State
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan coperment of Health and Mental Hygiene. It coperment of Health and Mental Hygiene. Im corrant: If item 27 is marked other than "natural", or items 23a or 28a-f show ain njury or other traumatic event, the Madical Examinar must be notified at 201 a.		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal f '4 ☐ Donation 5 ☐ Other (Specify)	rom State cemet	ery, crematory or	other place)		'25/04 S		
atin	pe mit. Pages Department of im crtant: if i an njury or on s.		21. Signature of Funeral Service Licensee	Fleaso						
ă	Dep m		Jany W.	nate	4925	Washingt Burrough	on & Sons Ave.,	ns Co.,I N.E.,Was	nc. hington,	D.C. 20019
н			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	on each line.	not enter the mo	de of dying, such	n as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	NTEMOSC	LENOSIC	Cano	701480	when Di	sease	Years
	/Medical Examiner		Du	e to (or as a consequence	e of):					
		Jer	Sequentially list conditions, b. Du cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence	e of):		<u> </u>			
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
,092	ate be executed nysician and he burial-transit	cal Ex	Du	e to (or as a consequence	9 01):					
687	ficate physis the		d			-				
Вох	h certi	M/U	230. was decedent pregnant	s, outcome of pregnancy ive birth 2 Fetal deat	th 3□Ectopic p	rognanov			23d. Date of de	livery
ю. В	e deat he att	Physician/Med	1 Yes 2 No	Pregnant at time of death Johnnown	5 Other (s				Month	Day Year
۵.	that the death certifica ed by the attending ph detached for use as th	Phy	9 ☐ Unknown Part II. Other significant conditions contributing	to death but not resulting	in the underlying	cause given in P	art I.	23e, Did tobacci	use contribute t	o the cause of death?
Records,	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Completed by	End Stape Renal		, ,			1 ☐ Yes	2 □ No 3 □ P	robably 4 🖅 nknown
00	s beer s shou	plete	Cenebral Thron	-5 osis				24a. Was an		utopsy findings available
æ	sician: The law certificate has t lirector, page 2 s	mo						autopsy performed?	death?	completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?					Check only one)		
of	ding Physician: The I h. After this certificate ha funeral director, page	. To			Outpatient 3 D	OA Other: 4 2 28c. Injury at		5 Residence		ecify)
O	Attending r death. ector: After by the fune	ition	1 €Natural 5 Pending (Month, Day Year)	Injury M	Work? 1 ☐ Yes 2		d. Describe now in	ary occurred	
Division	I or Attendi atter death. Director: A i in by the fu	Certification;	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, touilding, etc. (Specify)	farm, street, factor	y, office	28	f. Location (Street : City or Town, Sta	and Number or R	ural Route Number,
	ital or A urs atter rai Direc lled in by									
	To the Hospital or Attent within 24 hours after death of the Funeral Director: completely tilled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To Certifying	o the best of my knowledg he basis of examination a manner stated.	ge, death occurred and/or investigation	at the time, date n, in my opinion,	e and place, and death occurred	d due to the cause at the time, date a	s) and manner as nd place, and du	s stated. e to the cause(s)
	To the	Me	29b. Signature and title of certifier	_		c. License numb			ate signed (Mont	
	(4)		Bulling	worlh		001	852	- Se	TEMBE	51 22 2004
DE	CIVA		30. Name and address of person who completed	cause of death (Item 23a)	(Type, Print)		1 11		(- N - D	5n 22 2004
90	Sta	te.		32. Registrar's Signature	UECNS	DURY! LE	a M4	4 6/301	ue mi	, vo '4
	Registr		SEP 2 3 2004 Beau	It Spark	E P					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		rtificate of		, ,	leg. No.		1664
	Physic	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day	Year 3.	Time of Death
	Physic /Medi		LILLIAN	WRIGHT				Septemb			7:20 PM
1	Examir		4a. Facility Name (If not institution, giv	street and number)			4b. City, Town, or	Location of Death	4c. Count	y of Death	
			Manor Care of I				Large			ce Georg	
	Funeral Director		5. Social Security Number 6. S 133-09-3751 Usual Residence of Decedent	ex 7. Age (In yrs. □ M 2귳 F 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day November	, _{Year)} 1912 er 8	9. Birthplace Country) New Yo	(State or Foreign rk
	and the the		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Ir	side City Limits
	Mary Fed sh	ğ	MD Prince G	eorge's	Bowie					1	⊠Yes 2□No
	1 28e	9	10e. Street and Number			10f. Zip Code		1	0a. Citizen of	What Country?	
	36 o	Funeral Director	3903 Elite Stree	t		20	716		U.S.A		
	deat deat	ner	11. Marital Status	12. Was Decedent Ever in U	,S. 13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Ra	ce - American In	dian,
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show eny injury or other treumatic event, the Madical Examiner must be incitified at once.	۾	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		rYes, specify Cuba I□Yes 2⊠, No	an, Mexican, Puer Specify:	to Rican, etc.)	Special Special	ick, White, etc.	lack
9	72 ho netur	द्ध	15. Decedent's Ed	ucation	16a. Deced	ent's Usual Occup	ation		16b. Kind of B	lusiness/Industry	
Baltimore, Maryland 21215-0020	d within 7 giene. r then "r	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12th	College (1-4or 5+)		ent's Usual Occup kind of work done OO NOT use retired	auring most of wo d)	rking	Priv	ate	
g	oth oth	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ne (First, Middle, M	faiden Surnai	ne)	
<u>ya</u>	Menta Menta	To	James Brand	on			Mary	Thorn	ton		
Jar	2 sho and is ma	1	19a. Informant's Name/Relationship (7					ıral Route Number			
dî dî	end lealth m 27 her tr			ody/Grandaught				Bowie, Ma	aryland	20716	
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	lace of Dispos emetery, crem	sition (Name of natory or other place	ce)			City or Town, S	
ŧΪ	t. Pa tmen tant: njury		4 □ Donation 5 □ Other (Specify	VQ.		n Cemeter		9/29/04			
Bai	Depare Impor eny ir	5 0	21. Signature of Funeral Service Licen	300				B. Jenk Landover		uneral H	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death							oximate val Between
6	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Carcinomat						Onse	t and Death
	ed sit	ine		h Metastatic	Uteri	ne Cancer	•				
	and and I-tran	хап	Sequentially list conditions, if any, leading to immediate	Due to (or	ras a consequ	ience of).					
68760,	tificate be executed ig physician and as the bunal-transit	Medical Examiner	Seque mally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c							
687	ficate physics the	용	that initiated events resulting in death) Last	Due to (or	as a consequ	ence of):				į	
Box	nding use a	Ž		d			<u></u>				
ň	death e atte d for	icla	Part II. Other algnificant conditions co	atributing to death but not rock	ulting in the up	dorlying course give	on in Dart I	20h Did tot		Authoras As About	
j.	t the by the tache	Physician/	Tarri. Onlor argumount conditiona co	numbering to death but not resu	nang in tile am	denying cause give	enin Faiti.			ntribute to the ca 3 ☐ Probably	
S,	gned gned oe de	by F								- Tobasiy	*X onknown
DIVISION OF VITAL RECORDS,	Attending Priysician: The law requires that the death certificate be executed and earth certificate he executed ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed						24a. Was an perform	autopsy ed?	24b. Were aut available completio of death?	prior to
r	rnystctan: The law r this certificate has aral director, page 2	E						1 □ Yes	s 2√2 No	1 ☐ Yes	2 ☑ No
15a	ran: ortifica ctor. I	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one			T.
> -	nysta nis ce I dire	2	1 Yes 2 No		ER/Outpatient	3□ DOA Othe	or: 4 Nursing H	ome 5 ☐ Resider	nce 6 □Oth	er (Specify)	
ב ב	After the funera		27. Manner of Death 1 ဩNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	v injury occurr	ed	
OIS I	tendil death. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 Y	res 2□No				
	5 # # E	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree	et, factory, office		28f. Location (Stre City or Town,	eet and Numb State)	er or Rural Route	Number,
	nospi 14 hou Funer tely fill	edical (29a. Certifier (Check only one) 1	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death of on and/or inve	occurred et the time estigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, dat	use(s) and ma se and place, a	nner as stated. and due to the ca	use(s)
1	within 2 To the comple	Me	29b. Signature and little of certifier			29c. License	number	29	d. Date signed	(Month, Day, Ye	ear)
۱ ٔ	(-)			Muy		D3-	2261		9-22	-04	
,	12/	-	30. Name and address of person who co	mpleted cause of death (Item	23e) (Type, P						
	AC.		Dr.Richard Feldmap	9500 Annapoli	is Road	Lanham,	Marylan	d 20706			
	Sta		SEP 2 3 2004	32. Registrar's Signati	ure						

	1	For State Of IVIA Registrar	Ce.	rtificate of		•	Reg. No.) [31665
Physiciar /Medica	1	Decedent's Name (First, Middle, Last) CHARLES GETHMANN WEL	LEMEYER			2. Date of Dea Month Septemb	Day	Year 2004	3. Time of Death 11:20A M
Examine		4a. Facility Name (If not institution, give street and number) Casey House		4b. Cily, Town, o	or Location of Death $11\mathrm{e}$	1	4c. County Mont	of Death	ry
Funeral Director		231.86.6866 ^{1™ × 2□ F}	(In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 30	, Year) 1948	Cour	elace (State or Foreign atry) ington, DC
ow ow	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
a-feh	<u>.</u>	Maryland Montgomery	Silver	Spring					1⊠Yes 2⊡No
with the Mar		10.20 Comlary Lama		10f. Zip Code	201		10g. Citizen of \		itry?
ifier death wi		1020 Copley Lane 11. Marital Status 12. Was Decedent E	ver in U.S. 13.	209 Was Decedent of h		pecify Yes or No-	U.S.A	e - Americ	an Indian.
be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel; or items 23e or 28e-f ehow event, it would be a nittle of the formal of the	Dy ruit	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ N If Yes, 2 ☐ W If Yes, Give Year or Dates: V	0	If Yes, specify Cub 1 ☐ Yes 2 🔀 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		k, White, White	etc.
ed within 72 houygiene. Ner than "nature".	naia	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	pation during most of world)	king	16b. Kind of Bu	siness/Inc	dustry
within ene. than	dillo	Elementary/Secondary (0-12) College (1-4or 5- 5+ Years	+)	DO NOT use retire Scientist	d)		NASA		
e filed Il Hygi other	ָרָ מ	17. Father's Name (First, Middle, Last)		,010110100	18. Mother's Nam	e (First, Middle,	Maiden Suman	10)	
Mental Mental arked of attic ev	2	John Fletcher Wellemeyer			Jane Hi	.11			
12 sho		19a. Informant's Name/Relationship (Type, Print)			and Number or Rus				
1 and Health tem 27	-	Antonia D. Wellemeyer/Wife 20a. Method of Disposition	20b. Place of Disponentery, cree		ane, Silv	Date	20c. Location -		
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel; or eny injury or other treumatic event, Ita Manical Examinance.	_	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Fort Line	coln Crem	atory 20		Brentwoo	d, Ma	aryland
permi Depa Impo eny is		21. Signature of Funeral Service Licenses Noncy A. Vercen						prin	g, MD 20904
		23a. Part1. Enter the discusse, or complications that caused shock, or him failure. List only one cause on each line	θ.		ng, such as cardiac	or respiratory are	rest,		Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)	ic CNS Nec	plasms				- 27	
Examiner		Malianan	consequence of): t Melanoma	. Advanc	ed				
D = 0	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):						
ificate be executed g physician and as the burial-transit	Yalli	that initiated events C.	consequence of):						
sician buria		3.50.00	s somo quomo ony.						
		U							
	Clair	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 0	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	y		23d. Dat Moi	e of delive nth	ry Day Year
by the	1132	9 ☐ Unknown 9☐ Unknown							
se ingi	2	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause giv	ren in Part I.				e cause of death? ably 4 Unknown
The law require to has been stage 2 should	200					24a. Was a		Vere autop	osy findings available
	5					perfor	med?	leath?	2 No
Attending Physicien: Thrift death. ector: After this certificate by the funeral director, par	2	25. Was case referred to medical examiner? Hospital:		at 30 DOA Oth	26. Place of Deat				Homico
Physer this eral di	- -	1 ☐ Yes 2 ☑ No 1 ☐ Inpatier 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day)		" OLI DON	4 🗆 Nulsing no	ome 5 ☐ Reside 28d. Describe he			Hospice
ath. or: After ne funer	950	2 Accident investigation	Year) Injury		Yes 2 □No				
in Dirth	מבו וווווי	3 Suicide 6 Could not be determined 28e. Place of Injubilding, etc.	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural	Route Number,
the Hospitel	anical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state	examination and/or in-	n occurred at the tir vestigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)
To the within To the comp	M	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed	(Month, E	Ay, Year)
10		E HOME			4121	-8	9/	16/	04
10		30. Name and address of person who completed cause of de Charles Harrison, M.D., 60	ath (Item 23a) (Type.	Print) ter Mill	Road, Roo	kville.	Maryla:	nd 20	855
State		31. Date filed (Month, Day, Year) SEP 2 1 2004 32. Registra							
Registra		SEP 2 1 2004 / 22mer	a 19	1					

			State of M	laryland / Depa <i>Cei</i>	rtificate of			ene PNA () ()	31666
	Physici		1. Decedent's Name (First, Middle, Last) James William White	Jr			2. Date of Death Month 09	Day Year 15 2004	3. Time of Death 6:15am
7	/Medio Examir		4a. Facility Neme (If not institution, give street and number, HCR Manor Care Largo			4b. City, Town, or L Largo	ocation of Death	4c. County of Dear	
I	Funeral Director		000 00 5004 100 005	ge (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1/12/2	Year) 9. Birt 9 N	hplace (State or Foreign orfolk, Va
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County P • G •	10c. City, Town or Lo Mitche	cation 11ville				10d. Inside City Limits 1 Yes 2 □ No
	h with the 23a or 28e	al Director	10e. Street and Number 1602 Pebble Beach Ct		10f. Zip Code 2072	1	10	g. Citizen of What Co	untry?
020	72 hours after death with the Maryland "netural", or items 23a or 28e-f show adical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 ☑ Yes 2 □ If Yes, Give 7 Year or Dates	Ever in U,S. 13. \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Was Decedent of H If Yes, specify Cuba 1.1. Yes 2. No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: BI	
Baltimore, Maryland 21215-0020	filed within 72 hou Hygiene. ther then "netura ent, fre Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 2 +	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired Driver	vation during most of work d)	sing 1	6b. Kind of Business	Industry
land 2	e filed Il Hyg other	To Be Co	17. Father's Name (First, Middle, Last) James W. White Sr	Bas	DIIVCI		e (First, Middle, M r Mae M	faiden Sumame)	
, Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury op-other treumatic enongs.			hter 1602	Pebble		Ct Mitc		e,Md 20721
timore	t. Pages 1 tment of H tant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Marylan	natory or other place ad Veter	n Cemet	/22/04 ery C	hetlenHa	m,Md
Bal	permii Depar Impor any ir		21. Signature of Funeral Service Licensee						lville,Md
A. Carrier	Physician /Medical Examiner	ē	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limited listed to the cause (Final disease or condition resulting in death) Cance	r Of Lung Due to (or as a conseq	with M				Approximate Intervel Between Onset and Death
68760,	ificete be executed g physician end as the bunel-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a conseq	· · · · · · · · · · · · · · · · · · ·			 	
Box 687	eath certificete ettending phy: 1 for use as the	an/Medical	resulting in death) Last	Due to (or as a conseq	uence or):				
P.O.	requires that the death cert seen signed by the ettendin should be detached for use	y Physician/M	Part II. Other significant conditions contributing to death to Stroke	out not resulting in the ur	nderlying ceuse giv	en in Part I.			to the cause of deeth?
ecords	aw Is b	Completed by	Atrial Fibrilla	ation			24a. Was an perform	ed?	Were autopsy findings available prior to completion of cause of death?
tal B	Tage age	60	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes		☐Yes 2☐ No
Division of Vital Records,	0 to 20	tion: To B	examiner? 1 Yes 2 Vo 27. Manner of Death 1 Matural 5 Pending (Month, Date of Injunction) 2 Accident investigation		28c. Injur Wor	er: 4 Nursing Ho		nce 6 □Other (Spec	ify)
Divis	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In	ijury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 11 Certifying Physician: To the best 2 Medical Exeminer: On the basis of and manner st	of examination and/or inv	vestigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To the I within 2 To the I	M	29b. Signature and title of certifier		29c. Licens	51520		d. Date signed (Mont) 9 - 16 - 0	
	10		30. Name and address of person who completed cause of Bahram Pighdad, M.D.	death (Item 23a) (Type, 600 Large		Largo, M	Maryland	1 20774	
1	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	Sparks				

Amend item I per Phy., C836, 10/5/04 III.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barbara Helen Year 0657 **Physician** BARBARAS WOODWARD aka Woodward SEPTEMBER 1004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomeny SILVEN SPRINT HOUY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 8, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 83 1 □ M 2√ F Yrs. Pennsylvania Director 214-42-4102 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or Itama 23a or 28a-f ahow traumatic evant, the Medical Examinar must be notified at 1 □Yes 217 No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number filed within 72 hours after death with the Hygiene. then "natural", or Itams 23a or 3 3118 Gracefield Road, #CC502 20904 USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hygiene Important: If item 27 is marked other the any injury or other freumatic event, the once. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Miller Spangler Janet Elizabeth Arthur 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3118 Gracefield Road, #CC502, Silver Spring, MD 20904 William Hoyt Woodward/ Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan \$eptember 20 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2004 Crematory 21. Signature of Funeral Service Licenset Francis J. Solutions Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 AMMAUNE Wilter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATIONY FAILURG **Physician** /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIUS BUMMARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine FRATCIUME OF HIP certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ BORMONALL HABEL BORIN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 No 26. Place of Death (Check only one) Hospital: 1 ★ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Going to REFLUEGUADE - SUPPROJUTION After Injury 5 Pending investigation 1 Datural death. N 104 М 1 Yes 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 3118 GARGETISO RO., Sint State, 40 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 015236 SEPTEMBOL LO LOOP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHU Z WARDER INC IN25 (POCKULUS PI In25 LOCKULUE PIKE I ROOK VILLE , NO LOSSE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State souls SEP 22 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 12 per FH G836, 10/2//04 TT

		1 - Stete Registrer		Cei	tificate of L	Death	F	Reg. No.		31669
o Dhaniai		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Physicia Medic		Thinking M	chelle	A16-1	Hen		Octobe	er 4, 2	2004	4:28p
Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
		87 1/2 Liberty Stre	et			ninster		Carı	coll	
neral ector		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs 2页F 4.7	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec 9	h y, Year) 1956	9. Birthpi Coun Md	lace (State or Forei try)
> 2		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	antine					
notified at	ctor	Md Carroll	100.0	•	Westminst	er			11	0d. Inside City Limit 1 Yes 2 N
ust be not	Il Dire	10e. Street and Number 87 ½ Liberty Street	-		10f. Zip Code 21157			10g. Citizen of V USA	Vhat Coun	try?
- 54	y Funeral Director	1 Never Married 2 Married	Was Decedent Ever in Armed Forces? 1 Yes En No If Yes, Give 12		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	Blac	e - Americ k, White,	etc.
	d by	3 Widowed 4 Divorced	Year or Dates:			орослу.		Зреспу	blac){c
odical Ex	ete	15. Decedent's Educat (Specify only highest grade of	on ompleted)	(Give	lent's Usual Occupa kind of work done d	urina most of work	king	16b. Kind of Bu	siness/Ind	lustry
event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		no not use retired)			U.S. Go	vernn	nent
even	To Be	17. Father's Name (First, Middle, Last) Floyd Turner				18. Mother's Nam Melvina (Maiden Sumam	е)	
or other treumatic	_	19a. Informant's Name/Relationship (Type, Melvina Turner (mo	*		g Address (Street a					Code)
ther		20a. Method of Disposition		Place of Dispo	1 4 A A A A A A A A A A A A A A A A A A		Date ,			
ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetery, crer	K Cemeter)		Sykesvi	,	
any injury or other tre		21. Signature of Funeral Service Licensee	erbert	22 P	. Name and Addres	s of Facility Har	ight Fun	eral Ho	me &	Chape1
physician and street transit street burial-transit	dlcal Examiner	resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conse	equence of): equence of): equence of):	ipide has back	k pe		SE956		
d be detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	If yes, outcome of pregri 1□Live birth 2□Fer 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	y Day Year
uld be deta		Part II. Other significant conditions contrib	perten	STON		n in Part I.				e cause of death?
should	lete	Di	abenc	mel	htus		24a. Was a	n 24b. W	/ere autop	sy findings availabl
rector, page 2 :	e Completed	25. Was case referred to medical	1310-PV	Ilmon	an ar			med? de 2 No 1	eath?	pletion of cause of
directi	To Bo	examiner?	pital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	3 DOA Other	26. Place of Deat 4 Nursing Ho			r (Specific	
e funeral			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho			
I o the Funerel Director; Atter this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre sify)	eet, factory, office		28f. Location (St City or Town	treet and Numbe n, State)	r or Rural	Route Number,
etely fille	edical C	29a. Certifier (Check only one)	an: To the best of my kn On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the cared at the time, d	ause(s) and mar ate and place, a	ner as sta	ited. the cause(s)
Idmo	Me	29b. Signature and title of certifier	141001		29c. License	number	2	9d. Date signed	(Month, D	Pay, Year)
0) at	3		030	115		10151		
4										

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Daman Anand 10:00p ^M October 3, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Althea Woodland Nursing Home Silver Spring Montgomery 8. Date of Birth (Month, Day Oct. 11, 1928 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 □ F ⁴:466**-**78**-**4637 75 Yrs. Director India Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits irsi', or items 23a or 28a-f show Exempted in the position at MD Silver Spring Director Montgomery 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1000 Daleview Drive 20901 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or Item ony injury or other treumetic event, the Medical Expenses 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ♣ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malik Krishanlal Anand Vidya Vati Sabherwal Anand 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vikrant Anand/Son 416 Cascadilla Street, Ithaca, New Yo≇k 14850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 75 ☐ Other (Specify) 10/6/04 Beltsville, MD Chesapeake Crematory 21. Sign tury of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Avenue, Silver Spring, MD 20910 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Arteriosclerotic Cardovascular Disease vears resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably = 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cerebral Infarction 24a. Was an autopsy performed 2 **□**Mo 2 💢 No 1 ☐ Yes 1 Yes Division of Vital the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Hornicide within 24 hours To the Funeral 29a. Certifier 1 XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D01852 October 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Road, Hyattsville, MD 20784 Paul A. DeVore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State QCT Q 7 2004 Registrar Lenger

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oct. **Physician** Arnold 2004 Year J. Bethoulle 1300 M 5 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 311 George Ave. Essex Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 3, 1 924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-16-6697 Months 1 XM 2 ☐ F 80 Yrs Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Madical Examirtar roust be notified at 10d. Inside City Limits MD Director Baltimore 1 Yes No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 George Ave. 21221 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □X es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than any injury or other traumatic event, the Manne in injury or other traumatic event, the Manne Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Truck Driver 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Bethoulle Elizabeth Grupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnie Bethoulle / 7519 Tomahawk Court Baltimore MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OakLawnCemetery 10/8/04 Baltimore MD 14 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signatyne of Funeral Service Licensee <u>300 Mace Ave. Baltimore MD 21221</u> 23a. Part1. Enter the disease, or combilications that caused the death-shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Pnysician Arterioscleratio 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to [or as a consequence of] Examiner frany leading to mmedicause. Enter Underlying Cause (Disease or injury ed by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 🗌 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) 1XYes _2 ☐ No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 018667 October 6, 200 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trimble 4:11 CT, Luthenville, MD 21093 Militello 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 7 2004

DHMH 17 Rev 1/2001

State

Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 0 7 2004

Wo

32. Registrar's Signature

			1 - For State Registrar	State of M	aryland		artment rtificate					Reg. No.	Control of the Contro	31/	572
	Physicia	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	Year		e of Death
	/Medic Examin		Patricia Boz 4a. Facility Name (If not institution, give	zell street and number)			4b. City, T	Town, or	Location of	of Death	Octob		2004 nty of Death	10):00P
	LAGITHII	C1	Frederick Mem			al		eder					ceder	ick	
	Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. k	ast birthday)	If Under	1 Year Days	If Under Hours	Min	8. Date of Bir (Month, Da July 1	th ay, Year)	9. Birthp	lace (Sta	te or Foreign
	Director		216-44-1703 Usual Residence of Decedent	□M 2√√F 59)	Yrs.					July 1	6 1945	Md		
	land		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside	e City Limits
	Mary Ind	tor	Md Frederic	ck		Bradd	ock He	eight	ts					1 🗆 Y	∕es 2X No
	or 28s	lrec	10e. Street and Number				10f. Zip					10g. Citizen o	of What Cour	ntry?	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show intal Examinar must be notified at	Funeral Director	6012 Jefferson Bl	Lvd.			217	714				USA			
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decede If Yes, speci	ent of His ify Cubar	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		lace - Americ lack, White,		١,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No		1 Yes 2	No X	Specify:			Spec	cify: whi	te	
21215-0036	2 hou atura	ted	15. Decedent's Ed	l fucation		16a. Dece	dent's Usual	l Occupa	tion			16b. Kind of	Business/In		
215	within 7 ene. than "n	Completed	(Specify only highest gra	College (1-4or	5+)	life.	kind of worl DO NOT use	k done di e retired)	uring mos	t of worki	ng				
2	a filed wi Il Hygien other th		12			home	maker						mesti	2	
and	uld be fi dental H rked ot tic ever	Be	17. Father's Name (First, Middle, Last) Gerald Dixon						18. Mothe Eliza			, Maiden Sum	ame)		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hygiene. Item 27 is marked other than "netural; or items 23s or 28s-f show other traumatic event. Ite Medical Examinar must be notified at	ို	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	na Address					er, City or Tox	vn. State. Zic	Code)	
Σ	nd 2 sells ar 27 is r trau		Mr. Duane Bozzell (Sc				-					, MD 21			
Jre,	os 1 and 2 of Heelth item 27		20a. Method of Disposition	15 11 0	20b. PI	ace of Dispo	osition (Nam	e of her place	9)	C	Date	20c. Locatio	n - City or To	own, State	Э
Ē	Page ment of ant: tf ury or		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specification)			e Vie				0-07	-04	Sykesv	ille,	Md	
Baltimore,	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service Licentification	+ Herby	tru	- 1	2. Name and			наі		neral H		Char	el
	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death							Md 2178 errest,	4	Approxi	mate Between
	Physician	i n	Immediate Cause (Final disease or condition	A C	L	6.	cheti						- 0		nd Death
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8760,	death certificate be executed e attending physician and od for use as the buriat-transit	cal Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		,	160	0(11)	dent	an	I Stand	my Ash	nenti		
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of V	Physician: this certific ral director,	To	1 Yes 2 No	Hospital: 1 Inpat	ient 2	ER/Outpatie	nt 3 DO	A Othe	^{IE} 4□ Nu	ırsing Ho	me 5□Res	idence 6 🗆 C	Other (Specif	v)	
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury a <i>y Year)</i>	28b. Time of Injury		Bc. Injury Work			28d. Describe	how injury occ	urred		
isio	Attending in death.	cat	2 Accident investigation 3 Suicide 6 Could not b	e Ogo Diogo of In	Nume At ho		M	-	′es 2□	-	29f Location	Street and Nu	mharar Russ	J. Courte A	lum bas
Division	il or Attent after death Director: d in by the	Certification:	4 Homicide determined	28e. Place of Ir building, e	itc. (Specify	/)	reet, ractory,	, OTTICE				wn, State)	INDET OF HUTZ	ii Houle N	vurn <i>ber</i> ,
	Hospita 4 hours Funeral ely filler	edical C	29a. Certifier Certifying Ph (Check only one)	nysician: To the bes miner: On the basis and manner s	of examinat	wledge, deat tion and/or in	h occurred a evestigation,	at the tim in my op	e, date an inion, dea	id place, in occurr	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due to	tated.	se(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	/	- and the		29c.	License	number			29d. Date sig	ned (Month,	Day, Yea	r)
	r>=0		► J. PAR	1/M	n		1	137	178			10-3-	04		
	+		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)		, ,			2000		-	
_	,		J CHVISIOPH	er Fl	1011	19	610	NUR	TH	STRE	ET	BIUNS	wick	MO	2/7/6
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			. For	* -	aryland / Dep				-		•	
			1 - State Registrar		Ce	ertificate	of D	eath		Reg. No.	004	3 6 7 3
4	Physici	an	Decedent's Name (First, Middle, Land)						2. Date of Month		/ Year/	3. Time of Death
	/Medic	cal	to Fooility Note (If and invited in a six	BRUCE		45 City To		continuo of E			South of Dooth	2:40 PM
	Examir	ier	4a. Facility Name (If not institution, gin	SPIPAL		-		Location of D		4C.	County of Death N/A	
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	Director		219-16-6478	1 □ M 2 🖾 🛣	79 _{Yrs.}	Months	Days	Hours 1	Min. (Month Jan.	Birth Day, Year) 16, 192	5 M	aryland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation						IOd. Inside City Limits
	Maryll f aho	ρ	MD N/A				timo	re City	•			TXXYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "nature!', or items 23a or 28e-f ahow may injury or other treumatic event, the Medical Examinar must be indiffied at once.	Funeral Director	10e. Street and Number	Hull Street		10f. Zip C		21230		10g. Citi	zen of What Cou	
	death ms 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Deceder	nt of His	panic Origin	? (Specify Yes o	r No-	14. Race - Ameri	
9	or Ite	Fur	1 Never Married 2 MMarried	Armed Forces? 1 ☐ Yes 2 XX	N o	If Yes, specify		, Mexican, P Specify:	uerto Rican, etc.)	Black, White,	etc. hite
21215-0036	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Specify: W	
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þ	e filec other vent,	BeC	17. Father's Name (First, Middle, Las	")			1	_	Name (First, Mid	idle, Maiden	Sumame)	
/lai	should be ind Mental imarked c	ToE	Lean Wright					Cora			Unkn	own.
Maryland	and 2 sho saith and n 27 is my ser treums		19a. Informant's Name/Relationship Elmer E. Bruce/ Hus						or Rural Route No 1timore M		r Town, State, Zip 21230	Code)
ore,	of Head		20a. Method of Disposition 122 Surial 2 ☐ Cremation 3 [Domewal from State	20b. Place of Disp cemetery, cr	position (Name ematory or other	of er place)		Date		cation - City or To	
Ē	Pages ment of ent: If it ury or o		* 4 □ Donation 5 □ Other (Speci	fy)	Holy Cross		-	i	er 9, 2004		Ltimore Mai	ryland
Baltimore,	permit. Page Department of importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee Victor P.		Name and Charles 1501 Fas	Address L. St t For	of Facility bevens : rt Aveni	Funeral H ue, Baltir	me, Inc	yland 212	230
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,)	EUMON							Onset and Death
	/Medical Examiner		resulting in death)	a	a consequence of):							
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N	pet nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of injury	Due to (or as	a consequence of):							
	te be executed ysicien and te burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		□Ectopic preg	nancy			2	23d. Date of delive	
0.	the at	/slci	1 ☐ Yes 2 ◯ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	t time of death 5	Other (spec	ify)			- 1	Month	Day Year
Δ.	that the		Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cau	ise diven	n in Part I.	23e. [id tobacco u	se contribute to the	ne cause of death?
Records,	uires sign	d by		J		73	•				□No 3□Prot	
COL	w req	Completed							24a. V	Vas an	24b. Were auto	psy findings available
Re	ysicien: The lav is certificate has director, page 2	mo							_ p	utopsy erformed? es 20 No	prior to co- death?	mpletion of cause of
Vital		BeC	25. Was case referred to medical					26. Place of	Death (Check or		1 165	2 NO
of V	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpati	ent 3 DOA					5 ☐ Other (Specif	v)
0	ding Phy h. After thi funeral c		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury		:. Injury a Work?	at		be how injur		
isio	Attending Physicien: r death. ector: After this certific: by the funeral director,	icati	2 Accident investigated 3 Suicide 6 Could not be	De Bloop of Inc	inc. At home form	M		es 2 No	29f Locatio	on /Ctroot on	d Number or Rura	I Pouto Alumber
Division	I or Attendi after death. Director: A I in by the fu	ertif	4 ☐ Homicide determined	building, et	ury - At home, farm, s c. <i>(Specify)</i>	street, ractory, o	OTTICE			Town, State		i Houte Number,
_	To the Hospitel or Attenomitin 24 hours after death To the Funeral Director:	Medical Certification;	29a. Certifier Certifying P	hysician: To the best	of my knowledge, dea	ath occurred at	the time	, date and p	lace, and due to	the cause(s)	and manner as s	ated.
	he Ho in 24 i he Fu pletely	edic	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examination and/or i	investigation, in	n my opir	nion, death o	occurred at the til	ne, date and	place, and due to	the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	A	^		icense i		24	29d. Dat	e signed (Month,	Day, Year)
•			05/1	201A, 17	ロ) 1	26-	J 1		CT 5	, 2007
	0,		30. Name and address of person who		301 ST	PAU		PLACE	E BALL	TIMO	RE, MO	2004
	Sta		31. Date liled (Month, Day, Year)	32. Registr	ar's Signature							
	Regist	rar	OCT 0 7 2004	Benson	B	low						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BEACH 2004 14=55M Joseph DAVID 0 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HALFOLD BELARN UPPER CHEJA PERICE MEDICAL CENTUR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

70 Yrs. Months Days Hours Min. July 6, 1925 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** t∏M 2□F Maryland Director 217-12-0060 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itema 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Md. Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Beretta Way 21015 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years quality control supervisor automotive industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event 2008. Ernest Beach Gertrude Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Beach/wife 611 Beretta Way, Bel Air, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 10/9/2004 Baltimore, Md. ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AS Priysician CV /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed Amal 2 No Chronic 1 Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1XYes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ō 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 21809 2004 DME anish

State Registrar

0

YONK

11 MONIUM MD 21593

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

2 ABHU

OCT 0 7 2004

31. Date filed (Month, Day, Year)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

	Physici /Medio		Florence Elverta Behler OCT 5 2004 11:45 PM				
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BACTIMORE BALTIMORE(19)				
	Funeral Director		5. Social Security Number 188148342 6. Sex 1 Date of Birth 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Min. 1 Days Hours Nat. 2 Department of the second of the secon				
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits				
	Many	to	Maryland Baltimore Perry Hall 1□Yes 2♥No				
	th the	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?				
	ath wi	ral	3712 Perry Hall Road 21128 U.S.A.				
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hir Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.				
980	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Itama 23s or 28s-f show event, the Medical Examiner must be notified at	ğ	3 □ Wildowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify: Specify: White				
5-0	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of working most of working				
121	within ene. than "	этр	Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade World Book Encyclopedia				
92	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)				
/lan	2 should be filed within and Mental Hygiene. Is marked other than eumetic event, the Mental Bernest Be	ToB	Mentillios Hugh Kerr Elverta Jane Snyder				
Maryland 21215-0036	s 1 and 2 should f Health and Men fem 27 is marke other treumetic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) Mr. Franklin Behler (husband) 3712 Perru Hall Rd., Perru Hall, MD 21128				
e,	ges 1 and 3 t of Health If Item 27 or other tr		20a Mathod of Disposition 20b Place of Disposition (Name of Date 20c Location - City or Town State				
Baltimore,	00		1 \(\mathbb{R} \) Burial 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 1 \(\mathbb{R} \) Burial 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 2 \(\text{Cometery}, \) \(\text{crematory or other place} \) St. \(\text{Michael Luth Ch.Cem} \) 10/11/04 \(\text{Baltimore}, \) \(\text{Marijland} \)				
≡	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes				
B	\$ 0 E E 8		9705 Belair Rd., Baltimore, MD 21236				
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death				
	Physician /Medical		disease or condition disease or condition a. Hemorrhagic Shock 24 hmB				
	Examiner		Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events.				
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. End Orgen Damage Kickney, Brain, hongs 24 hong. Due to (or as a consequence of):				
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68760,	flicate phys	edic	d. 1301-11C 3400311				
Box	death certificate be executed e attending physician and id for use as the burial-transit	sician/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy				
O. E.	o o o	/sici	in the past 2 months? 1 Yes Year	<u>P</u> .	The law requires that the ate has been signed by the page 2 should be detach	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	quires n sign uld be	ed by	Systemic Liners Erythernton 1 yes 2 No 3 Probably 4 Junknown				
000	e taw require has been si je 2 should b	piete	Upper Gast to Intestinal Bleeding 24a. Was an autopsy findings available prior to completion of cause of				
Ä	The tate has page	Completed	autopsy performed? 1 Yes 2 No 1 Yes 2 No				
of Vital Records,	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Other				
5	Phys rrthis srai dii); To	1 Ses 2 No Hospital: Dispatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)				
ion	Ntending death. ctor: Afte y the fune	atio	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	spitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	To the Hospite within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
\	To To Te	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CF 05 700 4				
7	. 1		001				
	10		30. Name and address of person who completed cause of death (Item & 3a) (Type, Print) SALIM BAGHLI GOOD Sama Fran Hospital 5601 Baltimon 21238				
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
-	Registr		CCI 07 2004 Street & Sports				
U	HMH 17 Rev 1/2	uu1					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

		For State Registrar	State of Marylar	id / Depa		Health and	Reg	ene	31576
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Florence Louis 4a. Facility Name (If not institution, give s		own		or Location of Dea	2. Date of Death Month Septem1	Day Your 23 2	
Funeral Director		Genesis Eldercare 5. Social Security Number 217-40-3958 Usual Residence of Decedent	M 2 F 7. Age (In yrs.		Severn If Under 1 Year Months Days	la Park If Under 24 Hrs Min		Anne A 1916]	. Birthplace (State or Foreig Country) PA
filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or Items 23e or 28e-f show ant, the Medical Examiner must be molified at	ector	10a. State		len Bu			100	g. Citizen of Wha	10d. Inside City Limit: 1 ☐ Yes 2 ☐ No
ath with	Funeral Director	1922 Oakley Road			2106			U.S	S.A.
urs after de el', or Item Examiner o		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yes or No- to Rican, etc.)		American Indian, White, etc. white
be filed within 72 hours after death with the Marylar ital Hygiene. ad other than "neturel", or items 23e or 28e-f show other than "neturel" Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word)	orking 16	Sb. Kind of Busin	
m = 0 %	To Be Co	17. Father's Name (First, Middle, Last) James McGee Gut		Hus	re reach	18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
and 2 should be alth and Menta 127 is marked er traumatic ev		19a. Informant's Name/Relationship (Type Rev. Dr. James Kirl					ural Route Number, urnie, Mar	-	
permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic and one.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emova: nom State		esition (Name of matory or other pla Cemetery	I		ortage,	ty or Town, State
permit. Departr Importe any inji		21. Signatur ral Septice License	mo1319				ingleton F W., Glen		
ate be executed while burial-transit the burial-tra	licai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	unce of):	try di	SLAK	c or respiratory arres	π,	Approximate Interval Between Onset and Death
The law requires that the death certifica tte has been signed by the attending ph page 2 should be delached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	
w requires that the de been signed by the s should be detached		Part II. Other significant conditions cor	stributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.			ute to the cause of death? ☐ Probably 4 ☐ Unknow
The law restate has bee page 2 sho	Completed	<u> </u>					24a. Was an autopsy performe	prio dea	re autopsy findings availab ir to completion of cause of th? I Yes 2 No
Physiclen this certifii al director	To Be	1 162 5 5 60		ER/Outpatier	IL 3 DOA	her: 4X Nursing	ath (Check only one)	ce 6 □Other	(Specify)
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Speci	28b. Time o Injury	M 1	nyat nrk?]Yes 2 ☐ No	28d. Describe how 28f. Location (Stre	et and Number	or Rural Route Number,
To the Hospital or A within 24 hours after To the Funerel Direc completely filled in by		29a. Certifier 1 (Certifying Physical Certifying Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Cer	sicien: To the best of my known on the basis of examination	owledge, deat	h occurred at the ti	ime, date and plac	e, and due to the cau	ise(s) and mann	er as stated.
To the He within 24 To the Fe completel	Medicai	29b. Signature and title of certifier	and manner stated.	n	29c. Licen	se number			Month, Day, Year)
σ_j		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type,		P 10	te A Pava	dena M	0 21122
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign			Į.			

		4	For State	State of M	arylan			Health and M	Mental Hygie	ene	(A) 1.4	erry erry
		1	Registrar 1. Decedent's Name (First, Middle, Last)			Ce	rtificate of	Death	Reg	3. Nó.	i h	1 1 Death
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	xamine		4a. Facility Name (If not institution, give st	treet and number)			4b. City, Town,	or Location of Death	1	4c. County of Death	1	
			HOSPICE OF BALTIMO				W11-1-1-1-1	TOWSON		BALTI		
	neral ector		5. Social Security Number 6. Sex 1	M 2 F 7. AG	19 (<i>In yr</i> s. 93	last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day,) MAY 9,]	(ear) 9. Birth Cou	nplace (State of untry) N	ar Foreign Y
Pu	>	-	Usual Residence of Decedent 10a. State 10b. County			y. Town or Lo						
death with the Maryland	is and	.		TIMORE	100. 010	y, rown or Le	Cation	PIKESVIL	ıF		10d. Inside C 1 ☐ Yes	2 No
h the	or 28e	Director	10e. Street and Number	TITIONE			10f. Zip Code	TINESVIE		g. Citizen of What Cou		
ath wil	aust b	la La	6 POMONA SOUTH #6			-		21208			USA	
ter de	Items	Funeral	11. Marital Status 1 Never Married 2 Married 1	 Was Decedent Armed Forces? 1 ☐ Yes 2 X)	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White		
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Marylan tth and Mental Hygiene.	Exam	2	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□Yes 21X No	Specify:		Specify:	WHI	TE
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nd 2	vent,	BeC	17. Father's Name (First, Middle, Last)						ne (First, Middle, Ma	aiden Sumame)		
yla Ment	narkec natic e	0	MICHAEL	7.1		GOLDS		RAE			ICHMAN	
Mai nd 2 st	27 le n traun		19a. Informant's Name/Relationship (Type STANLEY GOLDSTEIN		FR		-			City or Town, State, Zi MD 21208	p Code)	
or es 1 ar	othe	-	20a. Method of Disposition	_·	20b. P	Place of Dispo	osition (Name of matory or other pla	· ·		c. Location - City or T	own, State	
Baltimore,	ury of		1 🕅 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		l	TH TFI	LOH CEME	TERY 10/		WOODLAWN,		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.	any in		21. Signature of FV Service Licenses	9	•					N & BROS., KESVILLE,		208
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	sician		Immediate Cau (Final disease or condition resulting in death) a.			cell	cancer	of face	2		Onset and	Death
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ords, P.O	igned by the attending p	by Pr	Part II. Other significant conditions cont	ributing to death t	out not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of c	death?
ords.	aen sig								1 🗆 Yes	2 No 3 Pro	bably 4	Ünknown
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tal F	ificate or, pag		25. Was case referred to medical					Of Plans of Dass	1 ☐ Yes 2	No 1 □ Yes	2□ No	
of Vital	direct	To Be	avaminar?	ospital:	ent 2 🗆	ER/Outpatier	nt 3 DOA Ct	hon	th (Check only one) ome 5 - Residen	Strait	(v) bosi	ice
OSK, Eillian Division of Vital Papilel or Attending Physicien: I	Viter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ly Year)	28b. Time o Injury	Wo	ork?	28d. Describe how		поор	
Division or Attending	tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	iuny - At ho	oma farm str	M 1 =	Yes 2 □ No	28f. Location /Stre	et and Number or Rur	al Route Nur	phor
No after	d in by	Certification:	4 Homicide determined	building, e	c. (Specif	y)	cot, ractory, onloo		City or Town,	State)	u / 10010 110//	,
SCSK, L.i. Divisio To the Hospitel or Attendi	To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Medical	29a. Certifier Check only one) Certifying Physical Examin	er: On the basis of	of examina	wledge, deat ition and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the cau	se(s) and manner as a e and place, and due l	stated. to the cause(s	3)
o the	ro the	Mec	29b. Signature and title of certifier	and manner st	ated.		29c. Licen	se number	290	I. Date signed (Month,	Day, Year)	
	7		Marland	our			DS	8303	a	croser 6	200	4
_	10		30. Name and address of person who cor	npleted cause of	death (Iten	n 23a) (Туре,	Print)	_	660 <u>1</u> N.	Charles S	treet 1204	
	Stat	e.	31. Clate filed (Month, Day, Year)	32. Registi	rar's Signa	ature			Tows	on, M:d. 2	1204	
	Registra		OCT 0 7 2004	Gerele	J.	Loon	E .					

			For State Registrar	State of Mary	-	artment of F			jiene _{eg.} No.00	31678
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	BRAVE	R			2. Date of Dea Month	th Day 4	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	L CENTER		4b. City, Town, o	STOWN.		4c. County of BALTIM	10RE
	Funeral Director		220 00 0000	T. Age (In	92 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birth Day	1912	9. Birthplace (State or Foreign Country) UKRAINE
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD BA	LTIMORE	c. City, Town or Lo	ocation	BALTIM	10RE		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	I Director	10e. Street and Number 3 AMLEHT COURT #	-1-C		10f. Zip Code	21215	1	log. Citizen of Wh	nat Country?
036	72 hours after death with the Maryland natural; or items 23a or 28a-f show deat Examinat must be mollind at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	i i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		n? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, White, etc. WHITE
Maryland 21215-0036	within ane. then *	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ER	durina most o	f working	16b. Kind of Bus	•
land	2 should be filed and Mental Hygi is marked other aumatic avent, II	To Be C	17. Father's Name (First, Middle, Last)		HARAN		18. Mother's	Name (First, Middle,		UNKNOWN)
	and 2 should lealth and Men m 27 is marke her traumatic		19a. Informant's Name/Relationship (7 YEVGENIYA BRAVER			ng Address (Street		or Rural Route Number	r, City or Town, S	
nore,	0 0		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐	Pamoual from State	20b. Place of Dispersion	osition (Name of matory or other place	ce)	Date 7004	20c. Location - C	ity or Town, State
Baltimore,	permit. Pag Department important: I any injury o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Septice Licen		2	2. Name and Addre	ss of Facility	SOL LEVINS	ON & BRO	•
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	/Medical Examiner		disease or condition resulting in death)	aDue to (or as a	nsequence of:	. 6	- i C	0		
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8760,	cate be executed oblysician and the burial-transit	dical Examiner	that intiated events 'resulting in death) Last	Due to (or as c.	nsequence of):	calem	لم ا			
.O. Box 6	The law requires that the death certificate be executed the sas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date Mont	of delivery h Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	underlying cause giv	en in Part I.	23e. Did to	. /	oute to the cause of death?
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ion of	ling After fune	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		of 28c. Injur Wor	y at		ow injury occurred	
Division	el or Atte s after de ni Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, st Specily)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospitel or Attene within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of ex- and manner stated	amination and/or in	th occurred at the tire	me, date and opinion, death	place, and due to the o occurred at the time, o	ause(s) and man late and place, ar	ner as stated. Id due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	13		29c. Licens	e number	25	29d. Date signed	(Month, Day, Year) U 4, 200 Y
	3		30. Name and address of person who	COMpleted cause of death	h (Item 23a) (Type	Print) Wr) -	- NW	HC	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	£9				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician Phyllis Marie Cercone** 10:56 A.M. October 4, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Columbia 6250 Soft Shade Way Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months 1 □ M 2 X F 62 Yrs. 194.32.9340 Director March 26, 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. ie marked other than "natural", or itams 23a or 28a-1 ehow sumatic event, the Madical Exchiler in author hostified a 1 Yes 2 No Director Maryland Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 U.S.A. 6250 Soft Shade Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) education Elementary/Secondary (0-12) College (1-4or 5+) teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Philomena Donatelli Nicholas Cercone 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 ie any injury or other trau 900.9. 16040 Avenida DEL Sol Sonora, CA 95370 Ms. Elizabeth Nester Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. MetMod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/11/2004 Pittsburgh, PA 4 □ Donation 5 □ Other (Specify) Calvary Cemetery 21. Signature of Funderal Service Licen 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 limbell 1253V Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MCTASTATIC OVACIAN Cancel **Physician** 22 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 🗆 Yes 2 100 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an filled in by the funeral director, page 2 a autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat a Funerel Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the ţ 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 0 MIS 17 10 108 38500 who completed cause of death (Item 23a) (Type, Print) Koutrolakos 11065 Columbia MO ZIO44 Varuxent Pky 32. Registrar's Signature 31. Date filed (Month,,Day, Year) State OCT 07 2004 Registrar

		-	- State Amend Item 1	State of Maryla	6,107079046 Certifica	hof Health and ate of Death	Mental Hygien	e 2004 31590
Ph	ysicia	ın	1. Decedent's Name (First, Middle, Last)	Essiah	Craig			ay Year 3. Time of Death
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			North West +	tospital		Randallstov	N	Batto.
	neral ector		5. Social Security Number 6. Sec. 15	M 2□F	rs. last birthday) If Uni Yrs. Month	der i Year If Under 24 Hrs is Days Hours Min		9. Birthplace (State or Foreign Country)
ō			Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Location		0 10	10d. Inside City Limit
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with the Maryland a or 28e-t show	penol	Funerai Director	10e. Street and Number	On al	10f.	Zip Code	10g. C	itizen of What Country?
death v	CENTRAL	erai	14 STRETNOM	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was De	cedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - American Indian,
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filed v	/ent, I	Be Co	17. Father's Name (First, Middle, Last)	N _{II}	ry	18. Mother's Na	me (First, Middle, Maide	on Sumame) (UNKNWN)
Maryland 2121: d 2 should be filed within ith and Mental Hygiene. 27 Is marked other then "	natic e	To	Essiah Craia, C	SR.				
Mar nd 2 st alth and 27 Is n	or other treumatic event, If a Medical Exactine mast be notified at		Prenetta Ellis (1	nuchter)	19b. Mailing Addr	ess (Street and Number or A	ural Route Number, City	or Town, State, Zip Code)
altimore, M	or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition (in cemetery, crematory)	or other place)		Location - City or Town, State
Baltimor permit. Pages Department of I	injury E.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		Garrison 1			vings Mills, MD
	eny ir		> Vaughr C.	2	8728	Liberty (Pd. C)	ampliston	energineral Services N.MD 21183
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not enter the n	node of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
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Box sath cert	for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3 Ectopic	pregnancy	100	23d. Date of delivery Month Day Year
P.O. I hat the ded by the a	detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□ Unknown	f death 5 ☐ Other	(specify)		World Day real
Records, P.O. Box 6 The law requires that the death certifi tte has been stoned by the attending	0 0	by PI	Part II. Other significant conditions col	ntributing to death but not r	esulting in the underlyin	g cause given in Part I.		use contribute to the cause of death?
Vital Records, stcien: The law requires to certificate has been stone	phould	Completed					1 ☐ Yes 24a. Was an	
The lay	9 2	omo			/		autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Fidelen: The Certificate	rector,	Be	25. Was case referred to medical examiner?	Hospital:			ath Check on one	
9 Phys	a d	n: To	27. Manner of Death	1 Ninpatient 2 28a. Date of Injury (Month, Day Year)		28c, Injury at	Home 5 Residence 28d. Describe how inj	
Division of or Attending Fatter death, Director: After	the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		М	Work? 1 ☐ Yes 2 ☐ No		
Division of a trend after death Director.	d in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, street, factorify)	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number. te)
Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death.	completely filled in by		(Check only 2 Medical Exami	sician: To the best of my k	cnowledge, death occurrination and/or investigat	ed at the time, date and plac	e, and due to the cause(s) and manner as stated. nd place, and due to the cause(s)
To the H within 24	omplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29d. D	ate signed (Month, Day, Year)
F 3 F	γ,		· Alice	1-1021		1-14397		
	7		30. Name and address of person who co	ompleted cause of death (II	tem 23a) (Type, Print)	1 /2	/ / /	char 4704
	Sta		31. Date filed (Month, Day, Year)	37. Registrar's Sig	gnaturely Ani	who profit	TA ICC	naglification, Income
R	egistr		act 0 6 2004	Commen	Ju jajot	us -		/

			For State Registrar	State of	Maryland /		artment of H tificate of I		Mental Hy	giene	04	3 68	
	Physici	an	Decedent's Name (First, Mid	_					2. Date of Do		Year	3. Time of Death	
	/Medic		Marie D. Cond								2004	8:51 a ™	
	Examin	er	4a. Facility Name (If not institution Upper Chesape		,		4b. City, Town, or Be1		ath		ty of Death arford	1	
	Funeral		5. Social Security Number		Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 H				lace (State or Foreign	
	Director		216-07-0427	1□M 2□F	92	Yrs.	Months Days	Hours Mi		ay, Year) 7, 1912		ew Hampshire	
	and w		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City, To	wn or Lo	cation				1	0d. Inside City Limits	
	Maryla f sho	ro		rford			rest Hil	1			, '	1 ☐ Yes 2√€ No	
	r 28a-	Funeral Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of	f What Coun	itry?	
	th with	al D	1 Colgate Dr:	ive			2105	0		United	d Stat	es	
	ems erra	ıner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. es?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No		ce - Americ	an Indian,	
36	s afte	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give			I □ Yes 2 No	Specify:	,		ify: whi		
21215-0036	72 hours after death with the Maryland natural", or terms 23a or 28a-f show deat Exarte at must be modified at	ed t	15. Decede	ent's Education		a. Deced	lent's Usual Occup	ation		16b. Kind of 8	Business/Inc	dustry	
215	within 72 ene. then "n	Completed	(Specify only high Elementary/Secondary (0-12	nest grade completed) College (1-4		(Give life. l	lent's Usual Occupa kind of work done o DO NOT use retired	during most of w	rorking			,	
21	filed within Hygiene. other ther ent, the Meritan Meri	Соп	12 years			sean	stress			clotl			
and	ntal H ad off	Be	17. Father's Name (First, Middle						ame (First, Middle		ıme)		
Maryland	2 should be f and Mental I Is marked of aumatic eve	은	Constantine l		19	h Mailir	g Address (Street a		opy Vlah		n State Zin	Code	
	5 # 7 F		C. James Cond				Carlo C			-	•	00007	
altimore,	permit. Pages 1 and 3 Department of Health Importent: If Itam 27 any injury or other tr. once.		20a. Method of Disposition 1 Burial 2 Cremation	2 CD 2 marrel from Ch	20b. Place cemet	of Dispo	sition (Name of natory or other place	θ) 1	Date	20c. Location	- City or To	wn, State	
Ë	Pages ment of I ent: If Its ury or o		`4 □Donation 5 □ Other			Α Δτ	natory or other place hodox Ca nn. Cem.	10	/4/2004	Baltir	nore.	Md.	
Balt	permit. Pages Department of Importent: If II any injury or o		21. Signature of Funeral Service	ce Licensee		22	Name and Address Schimun	ek Fune	ral Home	of Bel	Air,	Inc.	
	40580		23a. Part1. Enter the disease,	or complications that cou	and the death. De		610 W.	MacPhai	1 Road,	Bel Air	, Md.	21014 Approximate	
	Dharatataa		shock, or heart failure. Li	ist only one cause on eac	h line.		PAMAL					Interval Between Onset and Death	
}	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequence		MININC	HEI	OBEND	101		HOURS	
	Examiner		Paragraph to the second	H-									
	p #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	e of):							
	ecute and I-trans	xam	that initiated events resulting in death) Last	c. Due to (or	as a consequence	e of)·					-		
68760,	icate be executed physician and s the burial-transit	edical Examiner				J J.,.							
687	tificate ig phys as the			d									
Вох	eath certil attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	th 3	Ectopic pregnancy				ate of delive	•	
	e deal the att	sicia	in the past 12 months? 1 □ Yes □ No 9 □ Unknown		t at time of death		Other (specify)			М	lonth	Day Year	
P.0	that the de led by the a detached t		Part II. Other significant condi	itions contributing to dea	th but not resulting	in the u	nderlying cause give	an in Part I	23a Did	tobacco use cor	ntribute to th	e cause of death?	
Records,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	d by		g to tou	out not roouting	, 111 1110 21	iddifyllig daddd give	sit nt l'alt l.		Yes 2□No		V	
COL	w req	Completed							24a. Was	an 24b	Were autor	osy findings available	
	sicien: The law scertificate has b lirector, page 2 s	omp							auto		prior to cor death?	npletion of cause of 2 No	
of Vital	(i) her	Be C	25. Was case referred to medie examiner?	cal				26. Place of D	eath (Check only		1 1 1 1 1 1 1 1 1	20110	
of V	Physicien: this certificated ral director,	ို	1 Tes 2 No	Hospital: 1 🗌 Inc	-			4 Li Nursing	Home 5 ☐ Res	idence 6 □Ot	ther (Specify)	
	ding F	lon	27. Manner of Death 1 Selatural 5 ☐ Pen	uning .	Injury 28b Day Year)	. Time of Injury	Work		28d. Describe	how injury occu	irred		
Division	f or Attending after death. Director: Afte in by the fune	flcat	3 ☐ Suicide 6 ☐ Coul	stigation Id not be emined 28e. Place of	Injury - At home,	farm, str		Yes 2 □ No	28f. Location	Street and Num	ber or Rura	i Route Number.	
Ö	s after I Dire	Certification:	4 Homicide	building	, etc. (Specify)					wn, State)			
	To the Hospitel or Attending Physicien: within 24 hours after death. To tha Funerel Director: After this certific compietely filled in by the funeral director,		29a. Certifier Certify (Check only 2 Medic	ying Physician: To the b	est of my knowled	ge, death	occurred at the tim	ne, date and pla	ce, and due to the	cause(s) and m	nanner as st	ated.	
	the H in 24 tha F nplete	Medical	one)	al Examiner: On the bas and manne	r stated.	andvoran			curred at the time,				
	To To	Σ	29b. Signature and title of derti	TIPE A A	0		29c. License	number ()59	1125	29d. Date sign			
	1-		30 Name and	V V I TXVV	of death (the see	A (75-00-	(Print)	001	اللاا	040	のにて	4, 2009	
	10		BYIZNE	500 L	of death (Item 23a	CHT	SAPEC	WE	BEL	AIR, 1	WO -	Z, 2004 21014	
	Sta Regist		31. Date filed (Month, Day, Yea		pistrar's Signature	G	Lock	1		,			

		•	1 - For State Registrar	State of Marylar			of Health of Deatl			giene		3 682
	Dhyaiai	20	1. Decedent's Name (First, Middle, Las	Na C					2. Date of Dea Month	ith Day	Year ,	3. Time of Death
	Physici /Medic		Bonnie Ann		ny				10	4 3	1904	6:05 AM
	Examin	er	4a. Facility Name (If not institution, give		<u>سا</u>	4b. City, T	own, or Location	n of Death		4c. County		0 . 1
			5. Social Security Number 6. S	ex 7. Age (In yrs.	(ast hirthday)	If Under 1	Year I f Unde	er 24 Hrs.	8. Date of Birt	Anne		lace (State or Foreign
	Funeral Director			□ M 225F	49 Yrs.		Days Hours	Min.	(Month, Day	r, Year)	Count	try)
9			Usual Residence of Decedent			1				,		
arviar	ahow	_	10a. State 10b. County		ty, Town or Lo	cation					10	0d. Inside City Limits 1 ☐ Yes 2 No
- E	28a-1	ecto	MD Prince 10e. Street and Number	George's Cl	inton	104 75- 6	2040			10- 02:	47	
with	a or	급	6506 Clinton Mano	r Drive		10f. Zip 0				10g. Citizen of ' United		•
1215-0036 within 72 hours after death with the Maryland	ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U		Was Decede	ent of Hispanic C	Origin? (Spec	ify Yes or No-		e - America	
6 after	e le		1 Sever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specif	ly Cuban, Mexica	an, Puerto P	ican, etc.)	Bla	ck, White, e	
003	Tage Engl	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	ZNo Specify	y: 		Specif	^{y.} Whit∈	<u> </u>
5.7	and and	Completed	15. Decedent's Ed (Specify only highest gra		/Give	dent's Usual kind of work DO NOT use	done during mo	ost of workin	g	16b. Kind of B Hospita	usiness/Ind	lustry
T N	than than	ш	Elementary/Secondary (0-12) 12	College (1-4or 5+)		render				nospica	аттсу	
Q 5	Hygin other ent, I		17. Father's Name (First, Middle, Last)					her's Name	(First, Middle,	Maiden Suman	ne)	
lan ed ble	fental rked lic ev	To Be	Michael MacCart	hy			Mil	dred	GocHen	our		
Maryland 21215-0036	and N a ma		19a. Informant's Name/Relationship (**			Street and Num			•		
, M	n 27 In er tre		Mrs. Mildred Mac		_		idge Ac		-	Ferry,	WV 2	5425
Baltimore,	If iter		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispo cemetery, crei	sition (Name matory or oth	e of ner place)	Da O	ct 7	20c. Location -		
tim	tant:		`4 ☐ Donation 5 ☐ Other (Specify) Cl			ematory		004	Beltsvi		MD
Bal	Department of Health and Mental Hygiene. Important: If item 23 a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be nutified at once.		21. Signatur of Funeral Service Cer	Isee Mise			Address of Faci 10n and Green Pa				res Lmore,	, MD
			23a. Pan1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal one cause on each line.	h. Do not ent	er the mode	of dying, such a	is cardiac or	respiratory ar	est,		Approximate Interval Between
	nysician	8 H	Immediate Cause (Final disease or condition	a Metastati	c Vulv	a Carc	inoma					Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a consec	quence of):							
		<u>-</u> a	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence of):						-	
ted	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1	
O,	an and rial-tra	Еха	resulting in death) Last	Due to (or as a consec	quence of):	-						
8760,	physician and the burial-transit	dlcal		d								
c 68	ing pt	Med	IF FEMALE:									
Box 6	attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta	Il death 3	Ectopic pre					te of deliver inth	ry Day Year
O 4	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of of 9 Unknown	leath 5	Other (spec	cify)					
a . E	gned by the be detached	/ Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cau	use given in Part	ı I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
Records	n sign	d by							1 □ Y	es 2 🗆 No	3 Proba	ably 4 Mnknown
ecol		ompleted							24a. Was a	ın 24b. '	Were autop	sy findings available
Pe I	도 열	mo							autop: perfor	med?	prior to com death? I □ Yes 2	pletion of cause of
_	certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Plac	ce of Death	Check only or		103 2	
of Vita	S D	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA	Other: 4 - N	Nursing Hom	e 5€Resid	ence 6 □Oth	er (Specify))
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury at Work?		ld. Describe h	ow injury occur	red	
Vision	death ctor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2		06 Lanatina (C	4		2
- 6	in the	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	y)	eet, factory,	Office	28	City or Tow	n, State)	er or Hurai	Route Number,
Hospital	ours neral		29a. Certifier 1—Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at	the time, date a	and place, an	d due to the c	ause(s) and ma	inner as sta	ated.
HO.	within 24 hours after deatl To the Funeral Director: completely lilled in by the	edical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	ition and/or in	vestigation, in	n my opinion, de	ath occurred	d at the time, d	ate and place,	and due to t	the cause(s)
Toth	within 24 hours a To the Funeral C completely lilled	Me	29b. Signature and title of certifier			29c.	License number		2	9d. Date signe	d (Month, D	Jay, Year)
	· ()		> null	Ziri		D	23743		0	ct.05,2	004	
	7		30. Name and address of person who									
			Martin Weltz 75	25 Greenway Ct	Gree	nbelt,	, Maryla	ind 20	0770			
	Sta Registr		Martin Weltz 75 31. Date filed (Month Day, Year) 20	04 Sz. ryegistrar's Signa	G	Spo	uls					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2: 40 AM CAMM 6 eova ? 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2) Hospitaldin Glen Burnie North Arendel Hospital Anna If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral ¼** M 2□ F Months Days Hours Min. 73 8, Director 124-26-8614 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits orthan "natural", or items 23a or 28e-f show The Medical Examiner must be notified at Director MD 1 ☐ Yes 2√ No Anne Arundel Pasadena the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Drum Avenue South 21122 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No white Specify δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Analyst NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George L. Carr Marion Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Mrs. Kathryn Carr / wife 211 Drum Avenue South, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Importent: if ther
any injury or oth 1 Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation Oct 6,2004 Stevensville, MD 21. Signature Fund Service to 22. Name and Address of Facility Singleton Funeral Home P.A. Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PMO Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗌 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: After this c funeral dire 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 X R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. October M 11st 212001 11:05 PM 1 ☐ Yes 2 No 2 Accident investigation Dageman after death 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 211 Drum Ave To the Hospital o within 24 hours aff To the Funerel Di Pascetera, ME) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of centile 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD, GCEN BURNE OAHWOON 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rita Beverly DeLatte 6:20 a. September 27, 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) Ellicott City Howard 3417 Pierce Dr If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 83 439-14-8413 July 25, 1921 Louisiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3417 Pierce Dr. 21042 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married White 3 Widowed 4 ☐ Divorced

Physician

/Medical

Examiner

Director

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

t of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itama 23a or 28e-f show or other traumatic event, the Modical Examinar is ust by notified at

Physician /Medical Examiner

> attending physician and for use as the burial-transit been signed by the should be detached page 2 within 24 hours after death. **To tha Funaral Diractor:** After this certific completely filled in by the funeral director,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

3417 Pierce Dr.			21042	11211			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cub	tispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White		
15. Decedent's Ed (Specify only highest gra	ducation 1 de completed)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	16b. Kind of Busines	•		
Elementary/Secondary (0-12)	College (1-4or 5+)	_	ecretery	Clerical / Petroleum			
17. Father's Name (First, Middle, Last,			18. Mother's Name (First, Middle	le, Maiden Surname)			
Francis X	avier Hogan		Mar	guerite M. Lehne	•		
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural Route Num	ber, City or Town, State	Zip Code)		
Mr. David DeLatte	Son	3417 Pierce D	r. Ellicott City, Marylan	d 21042			
20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specif	Removal from State cem-	e of Disposition (Name of etery, crematory or other pla St. Rock Cemete	10/04/2004	20c. Location - City of New Orlea	or Town, State ans, Louisiana		
21. Signature of Funeral Service Lift of	John Mol293	22. Name and Addre Slack 3871 (ss of Facility Funeral Home, P A Old Columbia Pike Ellic	off City, MD 210			
23a. Part1. En the disease or shock, or heart failure. st only immediate Cause (Final	one cause on each line.	A =			Approximate Interval Between Onset and Death		
disease or condition resulting in death)	a. Pan (rentic		inome stasi	10	3 months.		
Sequentially list conditions, I arry, leading to hims obligate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent	ice of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 □Ectopic pregnanc	1	23d. Date of d Month	elivery Day Year		
Part II. Other significant conditions of	contributing to death but not resulting			I tobacco use contribute	to the cause of death? Probably 4 Unknown		
			24a. Wa aut per 1 □ Yes	opsy prior to formed? death?	autopsy findings available o completion of cause of		
25. Was case referred to medical examiner?	Hospital:	Ott	26. Place of Death (Check only		9		
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of 28c. Injury Wo	y at 28d. Secribe Yes 2 □ No	sidence 6 Other (Sp how injury occurred	ecify)		
3 ☐ Suicide 6 ☐ Could not be determined		e, farm, street, factory, office	28f. Location City or T	(Street and Number or I own, State)	Rural Route Number,		
29a. Certifier 15 Certifying Pl (Check only one) 2 Medical Example 15	nysician. To the best of my knowle niner: On the basis of examination and manner stated.	dgs, death occurred at the till and/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	to the cause(s) and manner as stated. le time, date and place, and due to the cause(s)			
29b. Signature and title of certifier		29c. Licens		29d. Date signed (Mor	oth, Day, Year)		
N	m . λ		10573	9-27-0	U		

DHMH 17 Rev 1/2001

State Registrar

Jon

31. Date filed

11065

Little Patoxent Parkway, Colombia

ress of person who completed cause of death (Item 23a) (Type, Print)

' WU

32 Registrar's Signature

6137

Ni KH

Day, Year) 0 7 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 804 **Physician** Harry S. Davis October 0 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ ★ 2 □ F 86 218-05-6535 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylan if Heetih and Mental Hygiene.
Item 27 is marked other than *natural; or items 23a or 28a-f show other traumatic event, I'm Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No **Baltimore** Director Cockeysville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 C. Knollcrest Place 21030 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XIX es 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: white 3 🔀 Xvidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Investigator Dunn & Bradstreet 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Davis Elsie Willis ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 ment of Heelth a ant: If item 27 is Daughter Roslyn Canosa 4203 Manorwood Drive GLen Arm, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 14 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. Woodlawn Cemetery 10/6/2004 Woodlawn, Maryland ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burger—Henss—Seitz Funeral Hone, 3031 Fails Koad Baltimore, MD 23a. Can 1. Enter the discusse, or complicator is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse in gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** somyo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence (Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has the irector, page 2 s 1 ☐ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 📜 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After aspital c. 4 hours after dea. ~el Director: Afte 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I wit in 2. To the F 29b. Signature and We of certified 29c. License number 29d. Date signed (Month, Day, Year) 0000412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 103 100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 7 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			1 - State of Maryland / Dep	eartment of Health and Nertificate of Death	Mental Hygie	2001.	31686
	#		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Helen V. Eder		October	Day 2004	10:25 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
ĝ.		é.	519 Valcour Road	Catonsville		Baltim	
	Funeral		5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 X F 81 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
	Director		218-14-8064 1 M 2 X F 81 Yrs. Usual Residence of Decedent		MAY 6, 1	923 Mar	ryland
	/land		10a. State 10b. County 10c. City, Town or L	ocation	 		10d. Inside City Limits
	Man 9-1 st	to	Maryland Baltimore	Catonsville			1 □Yes 2X No
	th the or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	death with the Maryland ms 23s or 28e-f show rmust be redified at		519 Valcour Road	21228		USA	
	r dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Decify Yes or No-	14. Race - Ame Black, Whit	
20	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 No Specify:			hite
-0003	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "neturel", or items 23s or 28e-f showevent, the Medical Examinar must be notified at	ed b	21	edent's Usual Occupation	166	. Kind of Business	
Ċ	in 72 n "na	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king	i. Kind of business	rindustry
7	d with piene or the	E	Elementary/Secondary (0-12) College (1-4or 5+) Med	dical Secretary		State H	ognital
and	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	den Sumame)	овртинг
<u> </u>		10	Frederick Ruff	Hatti	e Jane	Rollins	
Mary	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, Ci	ty or Town, State, 2	Zip Code)
≥ ~`	rtr 1			37 Davis Avenue		ock, MD	21163
Ö	Pages 1 annent of Hearnert: If item		20a. Method of Disposition 20b. Place of Disposition 1 XBurial 2 Cremation 3 Removal from State	ernatory`or other place)		. Location - City or	
saitimor	tmen tent:		4 Donation 5 Other (Specify) Cemetery	10	/8/04 E	llicott C	ity, MD
מ	permit. Pages Department of Importent: If i any injury or o		21. Signatura of Funeral Service Licensee Roward A. Gragorchik	2. Name and Address of Facility IacNabb Funeral	Home, P	. A .	
	440 4 40		Edward A. Gragorchik 23a. Parl 1. Enter the disease, or complications that caused the death. Do not er	BUL Frederick Ro	oad Cato	nsville	MD 21228 Approximate
	0.0		shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	G CANCEL			2 YEARS
	Examiner		Due to (or as a consequence of):				
Ľ		er	Satuentially list conditions if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
ĵ	be executed ician and burial-transif		resulting in death) Last Due to (or as a consequence of):				
Q/Q	ficate be executed g physician and as the burial-transit	dicai	d				
٥	death certificate e attending phys d for use as the	d3	IF FEMALE:			1	
X Q Q	eath certific attending p	hysician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of del	
5	the dea y the a sched fo	sici	1 ☐ Yes 2 ■ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
Į.	a S	0	Part II. Other significant conditions contributing to death but not resulting in the	underhing equips given in Port I	23a Did tehaga	a usa contributo to	the cause of death?
g,	requires that een signed b nould be deta	d by	The state of the s	andenying dadse given in raiti,	1 ☐ Yes		obabiy 4 □Unknown
ord	w requires that been signed be should be det	Completed			-		
ĕ	The lavate has by	mpl			24a. Was an autopsy performed	prior to	stopsy findings available completion of cause of
T T	ician: The lar ertificate has ector, page 2	e Co	25. Was case referred to medical		1 ☐ Yes 2 ☑		2 No
•		o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th (Check only one)		
0	ding Phys h. After this funeral di	-	27. Manger of Death 28a. Date of Injury 28b. Time of	AIL 3L DOX 4 Naising Ho	ome 5 Residence 28d. Describe how in		cify)
0	nding tth. r: Afte	atio	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
UIVISION	or Attending iffer death. Director: After in by the fune	HICK	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, si	treet, factory, office	28f. Location (Street		ıral Route Number,
5	s afte	Certification:	4 Homicide Setermined building, etc. (Specify)		City or Town, St	'are)	
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	-	29a. Certifier (Check only (Ch	th occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
	the H iin 24 the F nplete	ledic	and manner stated.				
	Con a with	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Monti	
,	, 5		The contract of the contract o	D16354	0c1	tober 6	, 2004
	13		30. Name and address of person who completed cause of death (Item 23a) (Type	(ATON AVE R	AITIMAC	s un	21219
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	CITO TIVE PI	- / / //C/R	2 10	XIXX)
	Registr		OCT 0 7 2004 Beneva &	CATON AVE B			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 816PN L. 04 Emley Harold 03 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Care Bultimore HOPKINS Johns center 2/224 Baltimore 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State of Foreign Country) 5. Social Security Number 6. Sex 1**□**M 2□ F Months 89 146-07-6475 New Jersey Usuet Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2√ No Dunda1k MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21222 2030 Codd Avenue 12. Was Decedent Ever in U.S. Armed Forces? %IXYes 2 ☐ No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3℃Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Dupont 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Mae Thompson Harry C. Emley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Mary McCue / fiance 2030 Codd Avenue, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) Chesapeake Cremation Oct 6,2004 | Stevensville, MD 21. Signature of Furneral Service License 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) asperation belura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EXAMINER to (or as a consequence of): WED BY SHALLION IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

certificate be executed

Box 68760

Division of Vital Records, P.O.

Hospital or Attending Physician:

after death.

24 hours a

filled in by

Physician

/Medical

Examiner

Director

by Funeral

Completed

Funeral

Director

Show

27 is marked other than "natural", or itame 23e or 28e-f abov traumatic event, the Medical Exempler must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after o Depertment of Heelih and Mental Hygiene. Important: if Item 27 ie marked other than "natural; or Item any Injury or other traumatic event, tra Medical Espariber PRODE.

Baltimore, Maryland 21215-0036

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Examine Physician/Medical <u>م</u> Completed Be

Certification;

ed by the ettending physiclen and deteched for use es the buriel-transit After this certificete hes been signifuneral director, pege 2 should be

within 24 ho To the Fune completely fi 10

Registrar

State

Grace

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending 1 Natural investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 4 Homicide home 29a. Certifier 29b. Signature and title of certifier

OCT 0 7 2004

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☑ No September 8, 2004 WA Kown M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred at 1 esidence

24a. Was an autopsy performed

2 No

1 Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2030 Codd Baltimore Md

Baltimore MD 21224

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

eted cause of death (Item 23a) (Type, Print) Corchs

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HOPKINS 32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nd. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** 12:15 AM /Medical 4c. County of Deeth Baltim City, Town, or Location of Death Fecility Neme (If not institution, give street Examiner actonsy SINC 8. Date of Birth Month, Day 5. Social Security Number 219-03-3164 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. 6. Sex Birthptace (State or Foreign Country) **Funeral** Months 1**№** M 2□ F maryland Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with 315 Ave USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 211No Baltimore, Maryland 21215-0020 Specify: ģ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry uith and Mantel Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Wor 18. Mother's Name (First, Middle, Maiden Surname) Father's Neme (First, Middle, Last) Be Marie -rederic Informant's Nam Malati nship (Type, Print) 19b. Mailing Addre s (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Hillenwood Rd. of Health Balto, MD Julammad 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location · City or Town, State 20a. Method of Disposition Department of Important: If It any injury or concept of the concep 1 Burial 2 □Cremation 3 □Removal from State Cemeter 10-9-04 Dundal K, Carmel 4 ☐ Donation /5 ☐ Other (Specify) Name an Address of Fecility 21. Signature of Puneral Service/License ary Balfo, mo à passer 21229 Iton prior to disease, or complications that caused the death. Do not enter of heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the daath certificate be executed Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last buriel-tren Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): use es the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No ata has been signed paga 2 should be de þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitat: Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this d in by the funeral di 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion death. 6 Could not be determined within 24 hours eftar dea To the Funeral Director completaly filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) end address of person who completed cause of death (Item 23a) (Type, Print) 25M au 31. Date filed (Month Day 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Anita С. Falise OCTOBER 4, 2004 9:50a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6117 MALORA ROAD BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 20, 1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 84 Director 215-05-2551 Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County 28e-1 show treumetic event, the Medical Examiner must be nutified at 1X Yes 2 □ No Director Baltimore Maryland N/A the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "neturel", or items 23e or. 21239 6117 Marlora Road S. Α. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Skirvan Anna Skirvan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tre 900. Michael Bogdan (Cousin) 5 Huntress Court, Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/6/2004 Baltimore, Maryland 21. Signal of Funeral Service Li lens 22. Name and Address of Facility Schimunek Funeral Home Inc. 1 3331 Brehms Lane, Baltimore, Maryland 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Immediate Cause (Final disease or condition resulting in death) Cardiovasialar **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Certification; To Be Completed by Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Dav 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: 1 X Yes 2 ☐ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) o Director: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death To the Hospitel or Attending Division 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. 2 Accident 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier um OCME OCTOBER 4, 2004 30. Name and address of person who completed cause of death (Item;23a) (Type, Print) PA rumer 111 Penn Street, Baltimore, Maryland 21201

State Registra

31. Date filed (Month, Day, Year) DCT **D 7** 2004 32. Registrar's Signature

			1 - State	artment of Health and Mental Hy rtificate of Death	ygiene Reg. No.? 0 0 4 3 1 6 9 0
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death
	Physici		Janet Reese Farley	Month O 9	25 2004 1245 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	LAGITIT		Carroll Lutheran Village	Westminster	Carrell
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D	irth 9. Birthplace /State or Foreign
L	Director		219-20-4542 1 N 2 F 77 Yrs.	Months Days Hours Min. (Month, Doct 25	, 1926 Califórnia
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	Aaryli	ō	100	inster	1 ☐ Yes 21 No
	28a-	ect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	with Sa or	Funerai Director	250 St. Luke Circle		
	death ms 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13.	21158 Was Decedent of Hispanic Origin? (Specify Yes or N	lo- 14. Race - American Indian,
ß	or Iter	Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
ĕ	rat', o	b	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: white
21215-0036	72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
7	ithin Ne.	npl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
7	lygier her th		12 5+	teacher	education
gu	build be filed within 72 hours after death with the Maryland Mental Hygiene. Are of the than "natural", or Items 23a or 28a-f show arked other than "natural", or Items 23a or 28a-f show atte event, It a Madical Exaction	Be	17. Father's Name (First, Middle, Last) Francis Sidney Reese	18. Mother's Name (First, Middle	
چ	should ind Men s marke umatic	To		Waiva Aileen D	
Maryland	d 2 sho th and 7 Is ma traum	8 4			
	1 an Heal em 2		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State
lo I	ages int of t: If it		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)	ematory or other place)	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examiner man be notified an once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility	
Ba	permi Depa Impo any ir		Ronald S. Wade Director St	tate Anatomy Board 655 Waltimore, MD 21201	. Baltimore Street
	4 1	,	23a, Part 1. Enter the disease, or complications that caused the death. Do not ent		arrest. Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	a Dala	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	a, end stage, mixe	2746
	Examiner		Atrial +	illation chron	d type
L		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying b. Due to (or as a consequence of):)	
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events c.		
Ö,	e exe		resulting in death) Last Due to (or as a consequence of):		
8760,	icate be executed physician and s the burial-transit	dicai	d		
9	ertific ding p	Mec	IF FEMALE:		
Вох	ath c	ian		Ectopic pregnancy	23d. Date of delivery Month Day Year
o.	the death certifi y the attending I iched for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	
ď	es that the death certificions of the attending I be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ds	uires sign ld be	d by	Hora Hypertension Hypoth	moradism. 10	Yes 2 No 3 Probably 4 Unknown
COL	w requir been s should	iete	Antigo Distriction	24a. Wa	s an 24b. Were autopsy findings available
Re	The law requires that ate has been signed b page 2 should be deta	Completed	Tramola, Ostopolis	auto perf	opsy prior to completion of cause of death?
Vital Records,	(4 L	e C	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only	2 No 1 Yes 2 No
>	Physician: this certific ral director,	o B	examiner? 1 ☐ Yes 2 ★No	Other V	
of		n: T	27. Magner of Death 28a. Date of Injury 28b. Time of	The state of the s	how injury occurred
jo	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1 Yes 2 No	
Division	l or Attendate death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
	ital o irs aff rat Di				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledicai	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and due to the exestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
	thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c License number	29d. Date signed (Month, Day, Year)
	T W C	-			
•			30. Name an address of person who completed cause of death (Item 23a) (Type,	Print)	1-21-04
			James L. Forsburg, New 1350	Print) Progress Way #114, Eld	Existing md 21784
	Sta	te	31. Date filed (Month, Pay Year) Registrar's Signature		11
	Regist		00107 2004 preserva 19	Sparks/	

			For State Registrar	St	ate of M	Marylan	d / Depa <i>Cei</i>	artment tificate				-	giene Reg. No.	001	į į	31691
	Dhysiai		1. Decedent's Name (First, Mic	idle, Last)					Ï		2	. Date of De Month	ath Day	Ye	əar	3. Time of Death
	Physici: /Medic	al .		nory		ust						Sept.	30		04	12:45A M
	Examin	er	4a. Facility Name (If not institu	_		er)		4b. City,		Location of			4c.	County of I		
			Sunrise Ass: 5. Social Security Number			Age (In yrs. i	last hirthday)	If Under		kvil		Date of Rin	th			nery
	Funeral Director		453-07-3256	6. Sex 1 ☑ M		90	Yrs.	Months	Days	Hours	Min.	Date of Bin (Month, Da oril 2	y, Year)			ace (State or Foreign ry) Mexico
			Usual Residence of Decedent								- A)	71 11 2	0, 1	714	TIEW	HEATCO
	how how		10a. State 10b. Cou	•		10c. City	y, Town or Lo								10	d. Inside City Limits
	Ba-f s	cto		ntgomer	У					cville	e 					1XXYes 2 □ No
	vith th	Director	10e. Street and Number	. 1				10f. Zip					111	zen of Wha		
	s 23s	erai	8 Baltimore		Inn Donado	nt Ever in U.	C 12 1	Man Doord		20850	ain? (Canai	fu Van as Na		ited		
	ter de	Funerai	 Marital Status Never Married 2 N 	A	rmed Force	s?	-			n, Mexican	n, Puerto Ri	fy Yes or No can, etc.)		Black, \		
936	urs af	by	3 X Widowed 4 □ Divord	ed If	Yes 2 Yes, Give ear or Date	s: WW I		1□Yes 2	24 5 7No	Specify:				Specify:	W	nite
21215-0036	be filed within 72 hours after death with the Maryland and Hygiene. And thy yield and the filed with the "natural", or teems 23a or 28a-f show or event. The Medical Examinat must be notified at	Completed	15. Dece (Specify only hig	lent's Education			16a. Dece	dent's Usua	I Occupa	ation	t of working	,	16b. Kir	nd of Busin	ess/Ind	ustry
21	C 2 100	npie	Elementary/Secondary (0-12		ollege (1-4d	or 5+)	life.	DO NOT us	e retired,)	i or working			_	_	
	filed w Hygier ther th		47 February Mines (Fires Mid-	W- ()	5+			Attor	ney	10 Matha	ata Nama /	First Adjuddle			Gove	ernment
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event. De M	To Be	17. Father's Name (First, Midd Frederick		nning	Fa	ust				isabet	First, Middle. Eh E	sthe		Jame	es
lan	s 1 and 2 should I Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relation				1	•				Route Numbe				Code)
	7.2 ₹ d		Camilla O. Mo	cRory /	Atto							401, R				20850
altimore,	000-		20a. Method of Disposition 1 ☐ Burial 2X Crematic	n 3 □Remo	al from Sta		lace of Dispo				Oct.			cation - Cit		
ţ	t. Pag tment tent: f	1.0	`4 □Donation 5 □ Other			Cne	sapeak				2004	+	Ве	eltsv	i⊥⊥€	e, MD
Bal	permit. Pag Department Importent: f any injury o once.		21. Signature of Funeral Serv	ohma	m	M0038	l R		uner	al ar	nd Cre	ematio er Spr				910
			23a. Part1. Enter the disease shock, or heart failure. I	or complicatio	ns that caus	sed the death										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Pros	tate C	ancer								Onset and Death Vears
	/Medical Examiner		resulting in death)		Due to (or	as a consequ		100 A 6 50 Ac Ac								
	Examiner		Sequentially list conditions,	b	H s. s.		nic De	rmati	tis							
	ed isit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or	as a consequ	uacica ot).								T	
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	с.	Due to (or	as a consequ	uence of):								-	
8760,	sician buris	ical													1	
687	ficate g physi as the l	e e		0												
XO	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant			ne of pregna ı 2 ∏ Feta		Ectopic pre	0000000				2	3d. Date of	f deliver	У
ω.	the attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		t at time of de		Other (spe						Month	ı	Day Year
P.0	at the de d by the stached	Phys	9 🗖 Unknown													44.40
ecords,	The law requires that the death certificate be executed tae is been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant cond	litions contribu	ting to deat	h but not resi	ulting in the u	nderlying ca	ause give	en in Part I.		*				bly 4 XXnknown
Sor	w require been si should t	Completed										24a. Was	an	24h Wer	e auton	sy findings available
Re	The lavate has	duo			 							autor		prior deat	r to com th?	pletion of cause of
		e C	25. Was case referred to med	ical						26 Place	of Death //	1 ☐ Yes Check only o		1 🗆	Yes 2	2 No
>	Physicien: r this certificated director.	ToB	examiner? 1 ☐ Yes 2 XX o	Hospi	tal:	atient 2 🗆	ER/Outpatier	nt 3 🗆 DO	A Othe			5 Resid		Other (Specify	1
			27. Manner of Death		a. Date of I	njury Day Year)	28b. Time o		8c. Injury Work			d. Describe i			. ,,	
ior	Attending I ir death. ector: After by the funer	atio	Z _ /\coldon	estigation	(,,	,)	М		Yes 2□I	No					
Division	ol or Attencatter death after death Director:	Certification:		uld not be emined 28	le. Place of building,	Injury - At ho	ome, farm, str	eet, factory	, office		28	f. Location (S City or Tox		Number o	or Aural	Route Number,
	urs af urs af sral D			Line Physics												
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier SXXCerti (Check only 2 Medione)	lying Physicial cal Examiner:	On the basi	s of examina stated.	tion and/or in	n occurred a vestigation,	at the tim , in my op	ie, date an pinion, dea	th occurred	at the time,	date and	place, and	due to	the cause(s)
	To the To the Comp	×	29b. Signature and title of ce	diar	1			29c	. License	number			29d. Date	signed (N	fonth, D	lay, Year)
)	3 1			M	KU				D35	792			(Octob	er 1	, 2004
	1041		30. Name and address of pers						· #5	504, 1	Rockvi	ille.	MD 2	20852		
	Sta	ate	31. Date filed (Month, Day, Ye	ar)	32. Reg	istrar's Signa										
	Registi	rar	QCT 0	7 2004	A a	men		100	uks	/						

State Registrar

29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

DCT 0 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

October 05, 2004

		Stat	e of Maryland / De			•	•	
		1 - State Registrar	•	ertificate of Dea			No. 00	31693
Physic	ian	Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Day Year	3. Time of Death
/Medi		Robert B. Gnagey				Oct. 4,	2004	5:45 P ^M
Exami	ner	4a. Facility Name (If not institution, give street ar Bluepoint Nursing Home		4b. City, Town, or Loca Baltimor			4c. County of Death	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birtho	(ay) If Under 1 Year If U	Inder 24 Hrs. p	B. Date of Birth	N/A	place (State or Foreign
Director		220-20-6238 1X M 2]F 78 Yrs	Months Days Ho	ours Min.	(Month, Day, Y Sept. 26	,1926 Ma	ryland
pus *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
Maryli feho	ō	MD Baltimore	e G1e	n Arm				1 ☐ Yes 2 XNo
r 28e-	Funeral Director	10e. Street and Number	323.	10f. Zip Code		100	g. Citizen of What Cou	ntry?
th with	aiD	12911 Kanes Road		2105	57		USA	
r dea	ner	Am	Decedent Ever in U.S. ed Forces?	 Was Decedent of Hispan If Yes, specify Cuban, Me 	ic Origin? (Speci exican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,	
s afte	by Fi	If Ye	Yes 2 □ No es, Give r or Dates: 45 1 - 46 1	1 ☐ Yes 2X No Sp	ecify:		Specify: Wh	nite
2 hours	ted	15. Decedent's Education	16a. De	ecedent's Usual Occupation		16	b. Kind of Business/In	dustry
thin 7:	pie	(Specify only highest grade compl Elementary/Secondary (0-12) Coll	eted) (G lii ege (1-4or 5+)	live kind of work done during fe. DO NOT use retired)	g most of working			
ygien therth	Completed	12 N,	/A Ra:	ilroad		(=)	Transpor	tation
I be fill hall H ad ott	Be	17. Father's Name (First, Middle, Last)			Mother's Name (uden Sumame)	
thould should and Me mark matic	2	Jacob R. Gnagey 19a. Informant's Name/Relationship (Type, Prin	t) 19b. M	lailing Address (Street and N	Bulah Be Sumber or Rural		City or Town, State, Zia	Code)
nd 2 s lith ar 27 is r trau		Sally A. Bruno/Sister		911 Kanes Roa		Arm, MD		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. In Medical Examinat must be reditted at any pines.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal	20b, Place of Di	sposition (Name of crematory or other place) n Forest	Oct. 8	te 20	c. Location - City or T	own, State
Page Page Tient ('4 ☐ Donation 5 ☐ Other (Specify)	Veterans	n Forest S Cemetery	2004		Owings Mil	ls, MD
permit. Departiments Imports any inj		21. Signature of Funeral Service Livensee		22. Name and Address of emmon Funera U w. radonia	Facility 1 Home o	of Dulan	ev Vallev.	Inc.
70560		Michael 23a. Paill. Enter the disease, or complications						Approximate
Physician	ı	shock, or heart failure. List only one cause	e on each line. Heroscleroti (Interval Between Onset and Death
/Medical Examiner		D. D.	ue to (or as a consequence of):					
	e le		ue to (or as a consequence of):					
cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
be executed sician and burial-transit		resulting in death) Last	ue to (or as a consequence of):					
cate b	dicai	d						
death certificate b attending physic	by Physician/Medi	IF FEMALE: 23c. If ye	s, outcome of pregnancy				23d. Date of deliv	an/
death a atten	cian	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
by the tacher	hys	9 Unknown 9	Unknown					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing	g to death but not resulting in th	e underlying cause given in	Part I.		cco use contribute to t	
aw rects bee	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
The The ate his	E O					performe	d2 death? No 1 ☐ Yes	2 1 No
cian: cian: ertific	Be (25. Was case referred be medical examiner?			Place of Death (Check only one)		
Physi this o	L.	1 ☐ Yes 2 No Hospital: 27. Manny of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpa Date of Injury 28b. Tim			e 5 Residence	be 6 ☐ Other (Special	(y)
ding the After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	ry Work? M 1 □ Yes		d. Describe now	injury occurred	
f or Attendi after death. Director: A	Certification;	2 Suicide 6 Could not be	Place of Injury - At home, farm	, street, factory, office	28	f. Location (Stre City or Town,	et and Number or Rura	al Route Number,
tal or rs afte el Dir	Cert	Tionnous	building, etc. (Specify)		<u> </u>	Only of Town,	State)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	edicai	(Check only 2 Medical Examiner: On	To the best of my knowledge, d the basis of examination and/o I manner stated.	leath occurred at the time, do or investigation, in my opinion	ate and place, an n, death occurred	d due to the cau at the time, date	se(s) and manner as s a and place, and due to	tated. o the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	٠٨.	29c. License nun		29d	. Date signed (Month,	
3	1	Malajapahre M			7465		10/5/0	•
0		30. Name and address of person who completed N.S. Rajapakst, M	cause of death (Item 23a) (Ty	pe. Print) in St. suite	700	Reister	A TOWN, N	10 21136
St	ate	31. Date filed (Month Day, Year)	32. Registrar's Signature	Mai. SME				
Regis		OCT 0 7 2004	en o	Sparks				

DHMH 17 Rev 1/2001

Pamela Arden Garcia Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06414 1- For Unpend Item 23ac27 per me G836 10:11-14 Las cmReg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** P^{M} October 04, 2004 4:28 Pamela Arden Garcia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 305 Joppa Road, Apartment 2010 Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 M 2 W 57 Yrs Director Nov 22, 1946 MD Usual Residence of Decedent death with the Maryland ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MD Baltimore Baltimore Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 United States 305 E. Joppa Road Apt.2010 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Eventhandone. Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21XNo Baltimore, Maryland 21215-0036 Specify: Specify þ 3 ☐ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wayne Alvin Mills Anna Mae Smarr 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Garcia/Son 3203 Chesley Avenue, Baltimore, MD 21234 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Scremation 3 ☐ Removal from State Oct 6 2004 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 XNO 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No this certificate has Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Certification: 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. October 05, 2004 aroe Hallan wa U Ø 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AROL H. ALLAN Md 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 7 2004 Registrar & Spale DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Ma	ryland / I	Department of Certificate or		Mental Hy	giene Reg. No.	2004	3 + 6 9 5
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Alma	Gray				10	_3	300L	10:10am M
}	Examin		4a. Fecility Name (If not institution, gir	re street and pumber)	1.1	4b. City, Town,	or Location of Deat	h i	4c.	County of Deat	h
			horien brankfor	Sex 7. Age	in yrs. last bi		more M	8 Date of Ri	rth	9 Rin	hplace (State or Foreign
	Funeral Director			1 M 2 K F 7. Age	63	Months Day		8. Date of Bi (Month, Da Jan 1,		Co	untry)
			Usual Residence of Decedent					jour 1,	151		
	how to		10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	Director	MD N/A		Balti			- 1	40 000	-/110 0	
	vith th		10e. Street and Number			10f. Zip Code				zen of What Co	
	s 23s	erai	5401 Gerland Ave	nue 12. Was Decedent E	ver in U.S.	21206	Hispanic Origin? (S	pecify Yes or N		ted Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, I've Medical Examinat must be notified at ance.	by Funerai	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 Yes 2 N		to Rican, etc.)	- 1	Black, White	
8	hour	edt	15. Decedent's E	100	16a	a. Decedent's Usual Occ	upation		16b. Kir	Whi nd of Business/	
5	n n	Completed	(Specify only highest gas Elementary/Secondary (0-12)	ade completed) College (1-4or 5+	.)	(Give kind of work don life. DO NOT use reti	ne during most of wo red)	rking	Own	Home	
212	d with giene greatha	ĕ	12			omemaker					
B	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Na				
yla	ould I Men warke	၉	Arthur Smith		- 10		Magdely				Zio Codo)
Maryland 21215-0036	12 sh hand 7 is m treum		19a. Informant's Name/Relationship Mr. Richard Gray			b. Mailing Address (Stre 401 Gerland					
e,	1 and Health em 2		20a. Method of Disposition	75011	20b. Place	of Disposition (Name of		Date		cation - City or	
ĕ	ages ant of t: If it		1 Burial 2 Cremation 3			ery, crematory or other papeake Crem	!	Oct 8 2004	Belt	tsville	, MD
Baltimore,	nit. Partme ortan injur		21. Signature of Funeral Service Jeich		Ches	22. Name and Add	tress of Facility				•
ã	Per a per a		> Stole Axoh	mann	M00382	8717 Gre	on and Fur een Pastur			atīves altimor	e, MD
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do	not enter the mode of d	lying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Luv	19 C	ancer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence						4
н	LXammer	<u>_</u>	Sequentially list conditions,	b. Due to (or as a	CODSEGUENCE	Effusion					- Week
Т	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Roo	1 -	W) a					1 week
	and and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a							0 1
8760,	icate be executed physician and s the burial-transit	dicai		La. Hy	poten	sion					2 weeks
9	ntifical ng phy as th	Medi	IF FEMALE:								
Box	leath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal deat				2	23d. Date of del Month	ivery Day Year
	the air	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at: 9□Unknown	ime of death	5 Other (specify)					
P.0.	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death bu	t not resulting	in the underlying cause	given in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ds,	w requires that been signed to should be det	d by	Advenal	Insuffici	ency			1 🖂	Yes 2	□No 3□Pr	robably 4 DUnknown
00	w req	iete			f			24a. Wa		24b. Were at	utopsy findings available completion of cause of
Re	The law ate has page 2 s	Completed						perf	opsy ormed? 2 🔯 No	death?	2 🖾 No
Division of Vital Records,		Be C	25. Was case referred to medical examiner?					ath (Check only			
<u>></u>	S	10	1 ☐ Yes 2 🖫 No	Hospital: 1 Inpatier		Julpatient 3 DOA		Home 5 Res			cify)
ū	ing Ph	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b.	Injury V	ijury at Vork? □ Yes 2 □ No	28d. Describe	now injur	y occurred	
isio	Attending ir death. ector: After by the fune	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 290 Place of Inju	ry - At home	farm, street, factory, offic		28f, Location	(Street an	d Number or Ri	ural Route Number,
Div	of or Attendate after death I Director: /	Certification:	4 Homicide determine	building, etc	. (Specify)	iam, shoot, labory, ome		City or To	iwn, State)	
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of eminer: On the basis of and manner sta	examination a	ge, death occurred at the and/or investigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as	s stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Dat	e signed (Mont	h, Day, Year)
	- s - o		VVI 7	awrence	, M)	$\mathcal{D} = \mathcal{D}$	51148		0t30	ber 5	, 2004
•	di		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, Print)	1);		1-		•
			1501 V	V. MJ. F	5040)	Ave Bol	D. More, 1	m 0 3	121	+	
		ate	31. Date filed (Month, Day, Year) OCT 0 7 200		r's Signature						
D.	Regist		JUL 1 (200	Sever	a for	Sporks					
UF	IMH 17 Rev 1/2	-001		-	3	-					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Albert Heinmuller, Jr. 6:52P M October _5 /Medical 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ridgeway Manor Nursing Home Baltimore

9. Birthplace (State or Foreign Country) Catonsville
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X**M 2□F Hours 216-09-4937 **Director** Nov 12,1910 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location in then "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 433 S. Rolling Road be filed within 72 hours after death Funeral 21228 USA 14. Race - American Indian, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WW Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Retail le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Sales Tax 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Albert Heinmuller Mary Elizabeth Pfeiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 le M. Elizabeth Heinmuller, Sister 433 S. Rolling Road Catonsville, MD 21228 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct 9 9 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1 4 Donation 5 Dother (Specify) 2004 Baltimore, Maryland 21. Signature of Funeral Sendo Licenso 22. Name and Address of Facility
MacNabb Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate

Approximate

Immediate Cause (Fig. 1) Immediate Cause (Final disease or condition resulting in death) **Physician** wk /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 9 2 autopsy performed Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ▼ No Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 3 atural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after deau...
To the Funerel Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36942

Registrar

State

redi

1009

Geneva

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 7 2004

MD

week

31. Date filed (Month, Day, Year)

i'ye Rd. Balkinere, My 21228

Amend item # 200, per FH, 6336, Department of Health and Mental Hygiana

		State of Marylan	Id 7 Department of Health and M Certificate of Death	Reg. No. 0 0 4 3 1 6 9 7
F	Physician	1. Decedent's Name (First, Middle, Lest)	Hartinger	2. Dete of Death Month Day Year 10 05 2004 12459M
F	/Medical Examiner uneral rector	4a Facility Name (If not institution, give street and number) Brooke Grove Nursing Rehe 5. Social Security Number 5. 9-42-9136 6. Sex 10 10 20 F 70	10.11	
Aaryland	r ahow ed at		y, Town or Location enwood	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	r flems 23e or 28e-fal niner must be notified Funeral Director	10e. Street and Number 14613 Burntwoods Road	101. Zip Code 21738	10g. Citizen of What Country?
:1215-UUZU within 72 hours after death with the Maryland ene.	Examiner must by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	,S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygiene.	*natur ledical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) budget analyst	16b. Kind of Business/Industry NASA
yland Z ould be filed Mental Hygid	\$ 5 a	17. Father's Name (First, Middle, Last) Joseph Hartinger	18. Mother's Name Maria Sc	e (First, Middle, Maiden Surname) nuierer
	27 is marked or traumatic every To B	19a. Informant's Name/Relationship (Type, Print) Mary Ellen Hartinger (spouse)	19b. Mailing Address (Street and Number or Run 14613 Burntwoods Rd.,	
no ages ant of	# >	4 □ Donation 5 □ Other (Specify)		Date Wheaton, Who State Wheaton, MD Where Ton, MD
Departme	impor eny in	21. Signature of Funeral Service Licensee Page daight Serbert	P.O. Box 195 Sykesv	ight Funeral Home & Chapel ille, Md 21784
/Mc Exa	ohysician and the bunal-transit and less the bunal-transit and less the bunal-transit and less than the less than	Due to (c	or as a consequence of): MKENTENT ON or as a consequence of):	Interval Between Onset and Death
OrdS, P.O. BOX 66/00, requires that the death certificate be executed	S O	Cause (Disease or injury that initiated events resulting in death) Last C Due to (o	r as a consequence of):	
thet the dea	been signed by the a should be detached f leted by Physic	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 ☑ ¥es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
lecords law requires	sate has been signed by the attending page 2 should be detached for use a Completed by Physician/M	MARKINGONS DISTARE		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Ear Fig.	i certificate has b lirector, page 2 s o Be Comple	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
on or ding Phy	After this funeral c	examiner? 1	ER/Outpatient 3□ DOA Other: 4 ursing Ho	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
DIVISIO To the Hospital or Attendit within 24 hours efter death,	To the Funerel Director: After thi completely filled in by the funeral Medical Certification: 1	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hospita 124 hours	Detely fill	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examina and manner stated.	wledge death control at the time data and place tion and/or investigation, in my opinion, death occurr	and due to the nause(s) and manner as stated ed at the time, date and place, and due to the cause(s)
To th within	To the	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1	()	30. Name and address of person who ampleted cause of death (Item	1 23a) (Type, Print) The other as was	0008h 5, 2004
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture 4	ound,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Cecil 2:30A M Heller 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7959 Telegraph Road Lot 64 Severn Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/30/1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 196-32-4173 61 PΑ Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercines must be notified at 1 ☐ Yes 2 No Director Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with It Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 2 7959 Telegraph Road 21144 Lot 64 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1961-1 Never Married 2K Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1963 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Shipping Clerk Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Cecil Fay Heller Blanche Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda M. Heller / wife 7959 Telegraph Road Lot 64, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oct. 6, Chesapeake Cremation 2004 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, P.A. Mark a MO1357 Vancur 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 1677-RS obaccc US (: Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Linknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 12 Yes 2 No 3 Probably 4 Unknown been holssteroleri 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Newsdence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ √√o this within 24 hours after death.

To the Funeral Director: After thi
completely tilled in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 50754 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 cunacion moment, m. D. h ERMI) HighWAU 0 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	Marylan		artment <i>rtificate</i>			and M	ental Hyg	iene	A Control of	31699
			Decedent's Name (First, Middle, L.	ast)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Southgate Yell	Lott Hammo	nd						October		2004	11:00A M
	Examin	-	4a. Fecility Name (If not institution, g	ive street and numbe	er)		4b. City, T	own, or	Location of	of Death		4c. Cou	nty of Death	1
			14627 Hanover H	Road			Upp	erc	0			Ba	altimo	re
	Funeral			Sex 7.	Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		215-16-0756	1 □XM 2 □ F	83	Yrs.					Jan. 3,	1921		MD
	Du &		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	anyla	٦ ا	Tod. State											1 ☐ Yes 2 ☑ No
	Ba-f	Directo	MD Baltir 10e. Street and Number	nore		Upper	10f. Zip 0	Code			1	0g. Citizen	of What Cou	intry?
	with t	ä		- 1			TOI. ZIP		1 5 5			•	JSA	21 (t. y)
	72 hours after death with the Maryland *natural", or items 23a or 28a-f ahow silical Exeminan must be nutified at	Funerai	14627 Hanover	Road 12. Was Decede	nt Ever in II	12	Was Decede		155	igin2 (Sne	orfy Ves or No-		Race - Amer	ican Indian
	item item	nu	11, Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	s?	7.5.	If Yes, specif	fy Cubar	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White	
36	rs aft	by F	3 Widowed 4 Divorced	1 XYes 2 (If Yes, Give Year or Date	s:		1□Yes 2	No No	Specify:			Spe	cify: Wh	nite
5-0036	hour		15. Decedent's			16a. Dece	dent's Usual	Occupa	ition			16b. Kind of		
Ċ		Completed	(Specify only highest g	rade completed)		(Give	kind of work DO NOT use	k done di	uring mos	t of worki	ng			
121	filed within Hygiene. other than out, the Man	E O	Elementary/Secondary (0-12)	College (1-4d	or 5+)		Electi	rici	an			E1e	ctrica	a1
D	be filed within 72 hatal Hygiene. d other than "natusevent, the Madical		17. Father's Name (First, Middle, Lat	st)					18. Mothe	er's Name	(First, Middle, I	Maiden Surr	name)	
an	should be filed withir and Mental Hygiene. marked other than matic event, the M	To Be	Charles L. Ham	mond					Maı	rv Ye	ellott			
Maryland	s 1 and 2 should it Health and Menitem 27 is marks other traumatic	-	19a. Informant's Name/Relationship			19b. Maili	ng Address ((Street a			I Route Number	City or Tox	wn, State, Z	ip Code)
<i>®</i>	and 2 s ealth ar n 27 is		Elizabeth C. Ham	mond Wii	fe	1462	7 Hand	over	Road	d. Ur	perco,	MD 21	155	
စ်	ges 1 ar t of Hea if item or other		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	e of	1			20c. Locatio		Town, State
0	ö O		1 Burial 2 Cremation 3	☐Removal from Sta	ite	arroll			· .	10/6/	04	Hamps	tead.	MD
altimore,			21. Signature of Funeral Service Lic		1 08		2. Name and					_		vn Road
Ba	permit. Departrimportu		Kam & C	Ilm	_	F	line l	Fune	ral I	Home	Reiste			
			3a. Part1. Enter the disease, or co	mplications that caus	sed the dea								11, 110	Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	h line.	~	0 .0.	TI.	,					Interval Between Onset and Death
	Physician /Medical		dise se or condition	a	noue	nucy	o pe	LUL	1				_	3 year
n	Examiner			Due to (or	as a consec	quence of .	1	EV	20	dal	1100			111221
4		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to for	as a consec	quence of):	1	() [6) NC		faclin			1 gent
	pe sit	Examine	cause. Enter Underlying Cause (Disease or injury	G	rues	21111	0	10	art		Faelin	P		4 400
_	and and	хап	that initiated events resulting in death) Last	c. Due to (or	as a compe	quence of):	-	,						7
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E												
	phys the	edic	`	d										
9 ×	es that the death certific igned by the attending p be detached for use as	/Me	IF FEMALE:	23c. If yes, outcome	me of pregn	ancy						23d.	Date of deli	verv
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnan	n 2 ∏Feta	al death 3	∃Ectopic pre ∃ Othe <i>r (spe</i>					- 1	Month	Day Year
P. 0.	the the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		304(1)	_ O(1) 07 (0) 00	,,						
	that the		Part II. Other significant conditions	s contributing to deat	h but not re:	sulting in the u	inderlying ca	iuse give	on in Part I	l.	23e. Did to	pacco use c	ontribute to	the cause of death?
S,	signe signed bed b	d by					, ,				1 🗆 Y	s 2 No	3 Pro	bably 4 Unknown
oro	w requir been si should	etec									24- 146	- 04	h 14/	han diadan ayadahla
Records,	e iaw has b	Completed									24a. Was a autops perform	n 24	prior to c death?	topsy findings available ompletion of cause of
		S										2 La No	1 🗆 Yes	2 No
Vital	Attending Physician: Th r death. ector: After this cartificate by the funeral director, pag	Be	25. Was case referred to medical examiner?					011		e of Death	(Check only on	(8)		
ot O	Physic this c	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inp		ER/Outpatie		_	4 🗆 140		me 5 Neside			eify)
П	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,	Day Year)	28b. Time o		Bc. Injury Work			28d. Describe h	ow injury oci	curred	
Division	endi eath. or: A	Certification;	2 Accident investigat	t bo		1	М		Yes 2□					
Ž	r Att	THE STATE OF	3 Suicide 6 Could no 4 Homicide determine	ed 289. Place of	Injury - At h , etc. (Speci	nome, farm, st rfy)	reet, factory,	, office			281. Location (Si City or Town		imber or Ru	ra l Route Number,
0	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			_11-										
	t hour unei	edicai	(Check only 2 Medical Ex	Physician: To the be caminer: On the bas	is of examin	owledge, dea ation and/or ir	th occurred a envestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the c ed at the time, d	ause(s) and ate and plac	manner as ce, and due	stated. to the cause(s)
	the F the F splete		one)	and manne										
	To To	Σ	29b. Signature and title of pertifier				290.		S number	15				n, Day, Year)
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	11/1		30. Name and address of person wh					1	0	Ac	u u	wster	unst	in 21157
_	11.		KHALIC	PREIJI		295	2	(5)	1	, , ,				
	St Regist	ate	31. Date filed (Month, Day, Year)		jistrar's Sign	nature	1120							

DHMH 17 Rev 1/2001

ODIGINIAL

	í	1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H rtificate of			ene 1. No.2 A A A	3 70	
		Decedent's Name (First, Middle, Last	")				. Date of Death		3. Time of Death	
Physici: /Medic		Viola T. Hayes					eptembe	r 25, 200		
Examin	er	4a. Facility Name (If not institution, give				r Location of Death				
		350 Baltimore & 5. Social Security Number 6. Se			Severn	a Park		Anne Arundel		
Funeral Director		215–14–8906	M 2∑F	ge (In yrs. last birthday) 90 Yrs.	Months Days	Hours Min	Date of Birth (Month, Day, York 3, 19	913 Vi	rthplace <i>(State or Fore</i> ou <i>ntry)</i> rginia	
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lin	
ane. than "netural", or items 23a or 28a-f ehow he Medicul Evaniner med Le netified at	៦	MD Anne Ar	unde1	Seve	rna Park				1 ☐ Yes 2x ☐	
28a-	Completed by Funeral Director	10e. Street and Number		30.0	10f. Zip Code		100	2. Citizen of What C		
3a or	Ö	350 Baltimore & A	nnanolia	D1***		11/6				
TIS 2:	era	11. Marital Status	12. Was Decedent			1146 lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-	USA 14. Race - Am	erican Indian,	
r Hor	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯	No			can, etc.)	Black, Whi	te, etc.	
E E	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	olack	
Ticket in	ted	15. Decedent's Edu (Specify only highest grad	ucation		dent's Usual Occup	ation during most of working	16	b. Kind of Business	/Industry	
e u	npie	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired	daning most of working				
and Mental Hygiene. Is marked other than surmatic event, the Mt.	S	6	0		ma:			housekeep	ing	
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (,		
a marke umatic	၉	Bennie Thompson					sia Dixo			
and is m		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street	and Number or Rural F	Route Number, C	City or Town, State,	Zip Code)	
n 27 n 27 ier tr		Marjory Wallace/f	riend	350	Baltimore	& Annarli	s Blvd S	Severna P.	ark. MD 2	
Department of Health and Mental Hygiene. Important: if item 23s or 28s-f show any injury or other traumatic event, the Medical Evanither mest be neithed at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ i 4 ☒ Donation 5 ☐ Other (Specify,)		nsition (Name of matory or other place	Dat	e 20	c. Location - City or	Town, State	
Departr Importa any inj		21. Signatur of Funeral Service Licens	wade, Div	stor St	Name and Addre tate Anat altimore,	ss of Facility Omy Board MD 21201	655 W. E	Baltimore	Street	
nysician (Medical xaminer prijal-transit	al Examiner	23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):		rentia			Interval Betweer Onset and Deat	
ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE:	4□Pregnant a 9□Unknown	2 Fetal death 3 time of death 5	Dectopic pregnancy Other (specify)		23e. Did tobac		Day Year	
been sig	ted	19/12	11 Deal	hells			1 Tes	2 Dano 3 □ Pi	robably 4 🗆 Unkno	
ate has be	ompie	٧					24a. Was an autopsy performe	prior to	utopsy findings availated completion of cause	
rtifica ctor.	Be (25. Was case referred to medical examiner?				26. Place of Death (6	/			
this certificanal director.	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 Inpatie	ent 2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing Home	5 Hesideno	e 6 Other (Spe	cify)	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju		M 1	/ at 286 ⟨? Yes 2 □ No	d. Describe how			
ours after eral Direction by		4 Homicide determined		ury - At home, farm, str. c. (Specify)			City or Town, S	State)		
within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Zi Medical Exami	iner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	occurred at the tin vestigation, in my o	ne, date and place, and pinion, death occurred	at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)	
ompl	Me	29b. Signature and fittle of certifier	1 ,		29c. Licensi	number	29d.	. Date signed (Mont	h, Day, Year)	
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Registrar

OCT 0 7 2004

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month ohnson **Physician** nuglass 3:20 AM September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number HOSPICE Battimore 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Yrs. Director Aug. 16, 1953 213-64-5039 maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Itams 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 Tes 2 No Director NIA mo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3653 Wahash USA Ave 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Never Married 2 ☐ Married 1 Yes 2 DNo
If Yes, Give
Year or Dates: 9 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify. δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Itam 27 Is marked othar the any injury or other traumeth University Heate Air Conditioning Tech. lath 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard William Johnson Bertha Freeman Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Johnson - brother Balto. 3653 Wabash Ave. mo 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 VCremation 3 Removal from State Catonsville, mo 4 ☐ Donation 5 ☐ Other (Specify) metro Cremator 10-5-04 21. Signatur 22. Name and Ad ress of Facility Gary P. March Funeral Home P.A. 270 Fredhilton Dass Balto, MD 21229 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or heart failure. Immediate Cause (Final dis ve or condition relating in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year detached for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performer Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 21 1 Yes Be 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 5 🔲 Residence 6 Other (Spec 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Injury Phaturai 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident

To the Hospital or Attending Physician: Certification: To Could not 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funaral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier

fr.

Registrar

State

OCT 07 2004

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend item # 26, per Medical Records, C836, 10//04 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death

Ragistrament First Middle Last)

Certificate of Death

Condective Name (First Middle Last) Reg. No. 70 3. Time of Death 2 Date of Death Day **28** Physician 5:50PM September 29. 2004 lackson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Baltimore Homewood Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 86 231-07-8973 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event. Its Medical Examinat her multipled at 1 Yes 2 No Baltimore ma Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA ASGARd COURI Funerai 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: BLack 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ring most of working Federal filed within nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Governmen Custodian 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be if Health and Mental I should be Imma GREEN William BazeMORE H ٥ 19a. Informant's Name/Relationship (Type, Print) MECC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ASGARd Balto.Co. Md. 21234 ICKIE Dunsen our Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Balto. Md 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō Important: If it permit. Page Department Baltimore Cometery N. Board a ay Borto Md. 39 21. Signature of Funeral Service Licensee 22. Name and Address of Facility / 6 once. Miller's Metropolitan Chapel f. 21213 27a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition allure 40 **Physician** /Medical resutting in death) Due to (or as a consequence of): Examiner x men Securiting list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performed? certificate 1 ☐ Yes 2 100 of Vital or Attending Physician: ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ္ရ ō this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel completely filled 29a. Certifier 1 🖵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2120 St. , Suite 30 821 Heade! N 3 MD au 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 07 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year 20VM Fecility Neme (If not institution, give street and number) 4b. City_Town, or Location of Deeth 4c. County of Death FustingAre le Catmsville onwons 6. Sex M 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days a6-22-Usuet Residence of Decedent 10b. County 10d. Inside City Limits Baltimore M 1 ☐ Yes 27 No 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) unk unk 1 Yes 2 H If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Catonsville Commons 16 Fusting Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Doord 21. Si nature of Funeral Selvi RODA and Address of Facility Anatomy Board 655 W. Baltimore Street State Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) . METASTATIC RENAL MONTAIS Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 1 Tes 1 ☐ Yes 2) (No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stete

Completed by Funeral Director

Funeral

Director

28a-f show

pemit. Pages 1 end 2 should be filed within 72 hours efter deeth with t Department of Health end Mentel Hygiene. important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Modical Examiner must be nonce.

altimore, Maryland 21215-0020

2

Menylend

within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, page 2 should be deteched for use es the burial-trensit or Attanding Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760

ģ Be Completed

Physician/Medical Examiner Medical Certification: To

25. Was case referred to medical examiner? 1 Yes ≥ No

27. Manner of Death 1 Naturet 5 Pending 2 Accident

4 ☐ Homicide 29a. Certifie (Check only one)

3 Suicide

6 Could not be determined

investigation

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28c. Injury et Work?

1 Tyes 2 No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, Stete)

STE 308, BACTIMURE MD 71201

Other: 4 Surrsing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) EUTAW

MANCH (EASAR 31. Date filed (Month, Day, Year)

OCT 07 2004

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

State

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For Stete Registrar	State of Marylan	•		of Health of Death			giene Reg. No.	0.	31704
	Dhusisi		Decedent's Name (First, Middle, Las					2	Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		K. MICHAEL						CTOBEC	1 4	2004	1)24 pm
4	Examin	er	4a. Facility Name (If not institution, give		C6 0	_	own, or Location		/		unty of Death ひして)か	07.6
			5. Social Security Number 6. Se	PMAL (LOV)								
	Funeral Director				32 Yrs.	Months	Days Hours	Min.	Date of Birt (Month, Da JAN . 16	1922	Coui	place (State or Foreign htry) MD
			Usual Residence of Decedent									
	show	_	10a. State 10b. County		y, Town or Lo	ocation	DIVE	CUTLL	_		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	Director	MD BALTI	MORE		1017		SVILL		10 - 02		
	with t	급	33 STONEHENGE CI	DCLE #2		10f. Zip (2120	10		USA	of What Coul	ntry ?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decede			v Yes or No		Race - Americ	can Indian.
ယ	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f show the Modical Examiran must be molified at	臣	1 ☐ Never Married 2() Married	Armed Forces? 1 M Yes 2 □ No WW If Yes, Give	II	_	ent of Hispanic Or fy Cuban, Mexica		án, etc.)		Black, White,	
21215-0036	ral', c	1 by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2	No Specify	/: 		Spe	ecify:	WHITE
5-(72 h natu	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual kind of work	done during mos	st of working		16b. Kind o	f Business/In	dustry
121	within	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	ATTOR	<i>DO NOT u</i> se NFV	e retired)			LAW		
d 2	be filed within 72 hours after death with the Maryla ital Hyghene. Id other then "natural" or Items 23a or 28a-1 sho avant, the Modical Examinat must be notified at		17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	1 //// / //	VIVE 1	18. Moth	ner's Name (F	irst, Middle,		name)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic avant, the M.	То Ве	LOUIS	D.	JEFFF	REY	JENN	NIE				KAPLAN
ary	ges 1 and 2 should tof Health and Men If item 27 Is marke or other traumatic.		19a. Informant's Name/Relationship (7		1		(Street and Numb					
	1 and 2 Health em 27		NATALIE JEFFREY				NGE CIRC					
Baltimore,	Pages 1 ar nent of Hea int: If item ; iry or othau		20a. Method of Disposition 1	Removal from State	Place of Dispo cemetery, cre	matory or oth	her place)	Date			on - City or To	
Ë	permit. Pag Department Important: I any injury o		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Firefall Service License				RLINGTON Address of Facil		2004	BAL	TIMORE	
Bal	permit. Page Department Important: If any injury or once.		INC.		1				OAD -	PIKESV		.EVINSON & MD 21208
			23a, Part1, Enter the disease, or comp	lications that caused the deat						-	,	Approximate
	Physician		shock, or heart failure. List only of Immediate Cayse (Final	a. ACUTE M	Jn (n	2010	1 ,010	22161	701			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	CUTT	1/25/	ROCCI I	Vav			
	Examiner		Sequentially list conditions.	b								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							
	xecuti and	хап	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
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Вох	death certifica attending ph d for use as t	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		⊒Ectopic pre	onancy			23d.	Date of delive	•
	e deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (spe					Month	Day Year
P.0	that the de ned by the a detached f	주	9 ☐ Unknown Part II. Other significant conditions co		ulting in the u	adachina aa	use sweet in Red		23a Did t/	phaese use s	ontribute to th	ne cause of death?
	ires tha signed d be det	by	Part II. Other significant conditions of	minoding to death out not res	ulling in the u	nderlying ca	use given in Pait	1.	1 🗆 1	\ .		ably 4 Unknown
of Vital Records,	w requir been si should	Completed							-			
Rec	has ge 2	μ							24a. Was autop perfo	rmed?	prior to con death?	psy findings available mpletion of cause of
a	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Plac	e of Death (C	1 Yes	2) No	1 🗆 Yes	2□ No
>	Physician: this certificanal director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatie	nt 3 DO	Other				Other (Specif	ν)
	g Phys terthis neraldi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ic. Injury at Work?			ow injury oc		
Ö	andin ath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investigation		,,	М	1 ☐ Yes 2 ☐]No				
Division	r Atta	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory,	office	28f	Location (S City or Tox	Street and Nu n, State)	imber or Rura	l Route Number,
Ω	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 X Certifying Ph	veicion: To the best of must be	nuladas de :	h once	t the time	nd place	I dua to the			Inted
	Hos 24 ho Funa etely f	Medical	(Check only one)	/sicien: To the best of my kno iner: On the basis of examina and manner stated.	ition and/or in	n occurred a vestigation,	it the time, date at in my opinion, dea	ath occurred	at the time,	date and plac	manner as si ce, and due to	the cause(s)
	To the within Fo the comple	Me	29b. Signature and title of certifier				License number				ned (Month,	
	X		· Call Fal	Can 18		0	00249	10	6	OCT OS.	360 4	4005,4
	10		30. Name and address of person who o	completed cause of death (Item	n 23a) (Type,	Print)	hijo.					2112
	`		CLIFFFABERMD		DVRS	RDA	D, RAND	DALLS	LOWN	MAG	2 YLAG	7, 2004 VD 21133
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature And	elle)	_					

			1 = For State Registrar	State of Mai	ryland /				ealth a Death	and M	lental F	lygien Reg. N	-20	04	7	705
	Physicia	an	1. Decedent's Name (First, Middle, Last)	VIT	TERM	AN					2. Date of Month	Death	ay 7	Year You	3. Time of	
	/Medic Examin		4e. Facility Name (If not institution, give st		TEICM	712	4b. City	, Town, or	Location o	of Death	UET	4	c. County			
	Lamin		HOWARD COUNTY	GENERAL	4204.	MAL		LUM						MAR	7	
	Funeral Director		5. Social Security Number 6. Sex 217.07.6497	7. Age	(In yrs. last b	virthday) Yrs.	If Unde Months	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of (Month,			9. Birthpi Coun	ace (Stete o	
	D		Usual Residence of Decedent								Septen	nber 20	, 1913		Virgini	
	e Marylan Ia-f show	ctor	Maryland Ho	ward	10c. City, To	wn or Lo	cation	i	Ellicott (City				10	0d. Inside Cit	
	th with th 23a or 26 ist be no	al Director	10e. Street and Number 4647 Manor Lane				10f. Zi	p Code	2	1042		10g. C	itizen of W		iry? S.A.	
2	urs atter deat	by Funer	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Every Armed Forces? 1 Yes 2 No lif Yes, Give Year or Dates:			Vas Dece Yes, spe		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-		- America k, White, e		
200	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic event, the Maulcal Examinar Libert to notified at once.	Completed by Funeral	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)			(Give	kind of wi	ise retired	uring most		ing	16b.	Kind of Bu		ustry nome	
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Mai	and 2 sho ealth and l n 27 is me	•	19a. Informant's Name/Relationship (<i>Typ</i> Mr. Otis Ketterman	e, <i>Print)</i> Sor			-				a/ Route Nu City, Ma	-		State, Zip	Code)	
ָם ס	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition Berial 2 Cremation 3 Re 4 Dodation 5 Other (Specify)	moval from State	20b. Place cemel	tery, cren	natory or	me of other place el Cem			Date 0/06/200		ocation -		wn, State Maryland	d
	permit. I Departm Importal sny inju		21 Signature of Funcial Service Licenses	0/ -	535		<u> </u>	nd Addres Slack	s of Facilit	al Hom	ne, P.A. a Pike E	llicatt C	ity MD	21042		
	Physician		23a. Part1. Enter the disease or complice shock, or heart failure. List only one Implediate Cause (Final disease or condition		the death. Do		er the mo						ity, ivid	21043	Approximate Interval Bett Onset and I	veen Death
	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Oue to (or as a	2005	TENC	TIV	FL	106	Disi	EASE				YEAR	25
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בי, ב	quires that in signed b uld be deta	by	Part II. Other significant conditions conf	•			, ,		1						e cause of d ably 4 □U	
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0 10	ding Phy h. Atter this funeral d	1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 285	Time of Injury		28c. Injury Work	at Nu		me 5 R			1-1)	
DIVISION OF	af or Atten after deal Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, (Specify)	farm, str	eet, facto			-		n (Street : Town, Sta		er or Rura	Route Num	ber,
	Hospite 24 hours Funeral letely tille	Medical C	29a. Certifier 11 Certifying Phys (Check only 2 Medical Examin one)	icien: To the best of er: On the basis of and manner stat	examination :	lge, death and/or inv	occurred vestigation	d at the tim	ie, date an pinion, dea	nd place, th occurr	and due to red at the tir	the cause ne, date a	s) and mai nd place, a	nner as stand due to	ated. the cause(s	
	To th within To th compl	Me	29b. Signature and title of certifier				29	c. License					ate signed			
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	り		30. Name and address of person who cor	in en	01 010	AN	Print)	is R), 5u	178 2	02,8			,		245
1	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 7 2004	32. Registra	r's Signature	A	1									

DHMH 17 Rev 1/2001

				1 - State Registrar	State of M		id / Depa	artment of I	lealth and N	Mentai Hy	giene	001	O 1 70	
		0		Registrar 1. Decedent's Name (First, Middle, Las	et)		Cei	rtificate of	Death	2. Date of De		***	3. Time of I	Death
		Physicia /Medic		Gerard James Kuhr	1					Septem	ber	30, 2864	2213	М
	7	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Death	ı	4c.	County of Death		
		Funeral		Upper Chesapeake 5. Social Security Number 6. Se			r last birthday)	Bel A	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	Harford 9. Birthpl	ace (State or	Foreign
		Director		134-28-4868 ¹ Usual Residence of Decedent	X ^{M 2□ F} 6	8	Yrs.	Months Days	Hours Min.	June 1	4, 19	936 New	York	
		yland how		10a. State 10b. County	1	10c. Cit	y, Town or Lo					10	d. Inside City	y Limits
		Ba-fs	Funerai Director	Md. Harford	1			Bel Ai:	r 				1 XYes	2 No
		with th	i Dir	10e. Street and Number 308 Hemingway Dri	ive			10f. Zip Code	21014		_	zen of What Coun ced State	•	
		death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		14. Race - America	an Indian,	
-0	36	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itams 23a or 28a-f show ant, the Medical Examinat must be mutified at	by Fu	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	MXYes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2 ∑XNo		rican, etc.)	1	Black, White, e Specify: whit		
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	/lan	should be land Mental I s marked o	To Be	Lawrence Kuhn					Mario	n Gueri	a			
+	Maryland	C1 — 00		19a. Informant's Name/Relationship (7 Marie Kuhn/wife	Гурө, Print)				and Number or Ru				Code)	
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30/08	E O	Page: nent o int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				Mem. Gdns		/2004	Be1	Air, Md.		
6	Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service Licen	see		22	Name and Address	ess of Facility K Funeral acPhail Re	Home of	E Bel	Air, In	с.	
19	760,	Physician /Medical Examiner e parual-trausit e parual-trausit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as Due to (or as	a noneaq	uence of):	rende	I mf				Onset and Do	Bath
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	s, P	res that signed to be det	by P	Part II. Other significant conditions of	ontributing to death t	ut not res	ulting in the u	nderlying cause giv	ven in Part I.			se contribute to the	1	
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ame	Record	The law ate has b page 2 s	Completed							24a. Was autor perfo	osy irmed?	24b. Were autop prior to com death? 1 \(\subseteq Yes	pletion of cau	vailable use of
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serarc	Division	To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor; After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ury - At he c. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (; City or Tox	Street and vn, State)	l Number or Rural	Route Numb	er.
Ge Ge		To the Hospital or within 24 hours after To tha Funaral Dircompletely filled in	Medical (29a. Certifier Certifying Ph	ysician: To the best iner: On the basis of and manner st	f examina	wledge, death	occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a	and manner as sta place, and due to	ted. the cause(s)	
_		To the within To the Comple	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month, E	ay, Year)	
				Dans 50	(i	>		123	2255		ocil	8001,	2007	
		20		30. Name and address of person who	completed cause of a	death (Iten	n 23a) (Type,	Print)	A. I R					
		Sta Registr		31. Date filed (Month, Day, Year) GCT 0 7 2004	2. Registr	ar's Signa	ature	Sparks				-		

		1	For State Registrar	State of Ma		d / Depa	artme	nt of H		1		ne	04	317	107
10			Decedent's Name (First, Middle, Last)							2. Date of	Death			3. Time of	Death
Phys		1	Carnell Keith							Septen	ber	24.	2004	12:20) PM
/Me Exan	dica		la. Facility Name (If not institution, give :	street and number)			4b. Cit	y, Town, o	Location of De				ty of Death		-
CX	IIIIIC		1400 Mosher Str	ceet 2nd	f1r			Ba1	timore						
Funer Directo			77/10/30/1	7. Age	75	Yrs.	If Und Month	er 1 Year Days	If Under 24 H Hours M		Birth Day, Yes	1917	Cour	lace (State of etry) :h Caro	
pue *		- }-	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation							0d. Inside Ci	ity Limits
ne Maryli 8a-f eho		Ctor	MD				ltir							† ▼ Yes	
with the se or 2	Ž	5	10e. Street and Number 1400 Mosher Street	2nd f1r			101. 2	ip Code	21217		10g.	USA	What Cour	itry?	
leeth		e a		12. Was Decedent i	Ever in U.S	S. 13. V	Was Dec	edent of H		(Specify Yes or	No-		ace - Americ	an Indian,	
ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. In of Health and Mental Hygiene. In of Health and Mental Hygiene. In or other traumatic event, the Muclical Examinar must be notified at		2	1 Never Married 2 Married 3 Midowed 4 Divorced	Armed Forces? 1 Yes 2 Pr If Yes, Give Year or Dates:		1		ecify Cuba 2☐ No	Specify:	(Specify Yes or erto Rican, etc.)		Spec	ack, White, illy: BL	etc. ACL	
d within 72 hours aff giene. er than "natural", or the Modical Exerci-		Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	i+)	16a. Deced (Give life.	kind of v DO NOT	vork done use retired	during most of v t)	vorking	16b		Business/In		
illed withi Hygiene. other them		5	6	0			tru	ick d	river				meric	a1	
Maryiand Id 2 should be file Ith and Mental Hy 27 ie marked oth traumatic event		lo Be	17. Father's Name (First, Middle, Last) P.K. Keith							ame (First, Mide amie Cip		len Suma	ame)		
2 sho and I ie ma			19a. Informant's Name/Relationship (Ty							Rural Route Nur				Code)	
and and lealth m 27	1		Conza Mae Keith/da	ughter	20h DI				eet Dar	lington,				0	
Part Part			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F * 4 ☐ Donation 5 █ Other (Specify)		20b. PI	ace of Dispo emetery, cren	natory o	ame or rother plac	:0)	Date	200.	. Location	- City or To	own, State	
Demit. Pa Departmen Importent:	once.		21. Signature of Euneral Sentice Licens ROna Lu	lade Dice	ector				ss of Facility Omy Boat MD 21	rd 655 W	• Ва	altim	nore S	treet	
S/60, ale be executed Aysician and he burial-transit	er	cal Exa	show, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	XYR	a consequ a consequ	pence of)	lu	Cary	des	case	Cv.	d	lsed	Interval Bet Onset and I	Death
OX OX OX br>OX OX OX OX OX OX OX OX OX OX OX OX OX OX O		by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel	death 3	Ectopic Other	pregnancy specify)	,		_	1	Date of delive	*	Year
D ta de de de de de de de de de de de de de		d by Pr	Part II. Other significant conditions co	ntributing to death b	ut not resu	ılting in the u	nderlying	cause giv	en in Part I.			ouse co	100	ne cause of d	
The lay ate has page 2		Completed								1 ☐ Ye	topsy informed s 2/2		. Were auto prior to co death? 1 \(\sum \) Yes	psy findings mpletion of c	available cause of
	1	Be	25. Was case referred to medical examiner?	Hospital:	- O []	ED/Outset		Oth	or.	Death (Check on	Acros in the	• 🖽 •			
n or ng Phy fter this		tion; To	27. Manner of Death	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time of Injury		28c. Injur Wor	y at	28d. Descrit			ther (Specif urred	γ)	
DIVISION OT To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: Attentis completely filled in by the funeral to		Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, fact			28f. Location City or	n (Street Town, St	and Num ate)	n <i>ber</i> o <i>r Rura</i>	I Route Num	nber,
Hospita 24 hours Funerel		edical C	29a. Certifier (Check only one) Certifying Phy Medical Exami	sician: To the best iner: On the basis o and manner sta	f examınat	wledge, deat tion and/or in	h occurre vestigati	ed at the tir	ne, date and pla pinion, death o	ace, and due to t courred at the tin	he cause ne, date	e(s) and n and place	manner as s e, and due to	tated. the cause(s	s)
To the within To the		Mec	29b. Signature and title of certifier	Mo	XI	7/12	20	9c. Licens	9 / 0	8	29d.	Date elgr	ned (Month.)	bay, Year)	
			30. Nume and address of person who co	ompleted cause of d	SV /	23a) (Туре,	Print)	10 R	5-	1-	SAU	LTI	MOR	921	121
	Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	1	,		_					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	arylan				Mental Hy	()	001		21700
			Registrar 1. Decedent's Name (First, Middle, L	actl		Cer	tificate of	Jeain	2. Date of De	Rag. No.	UU	1	01/00
п	Physicia	an	Walter Sugden	•					Month	Day	Υ	ear	3. Time of Death
	/Medic	al									04		6:15 a ^M
7	Examin	er	4a. Facility Name (If not institution, gi		. Car	o Ctn	4b. City, Town, or				County of		
			Collington Epi 5. Social Security Number 6.			ast birthday)	If Under 1 Year	hellvil					orges
	Funeral Director			15√M 2□F /. Ag	93	Yrs.	Months Days	Hours Mir	(Month. Da	av Year)	.11		lace (State or Foreign try)
			319-07-4976 Usual Residence of Decedent	Λ	93		L		June 2	9, 19	11	wes	t Virginia
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	Many -fish	tor			Wa	shingt	on, DC						1⊕Yes 2□No
	the 28a	rec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of Wha	at Coun	try?
	3a o	0	1517 P Street	. N.W. #3			20	005		Un	ited	Sta	tes
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Specify Yes or No		4. Race -		
ယ္	after or ite	Ē	1 ☐ Never Married 2 ☐ Married	Amed Forces?		1			rto Rican, etc.)		Black,	White,	etc.
ဗ္ဗ	al', c	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	194	5	1□Yes 21 No	Specify:			Specify:	wh	ite
21215-0036	72 hc	Completed by	15. Decedent's I (Specify only highest g				tent's Usual Occup		orkina	16b. Kir	nd of Busin	ness/Inc	lustry
7	an ".	nple	Elementary/Secondary (0-12)	Cotlege (1-4or 5	i+)	life. I	DO NOT use retired)	Jiking	Me	dical	ı	
21	ad wi	Con		+4		Orti	nopedic S	urgeon		110	wica-		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las						ame (First, Middle				
yla	Meni Meni arke	ပ္	Charles Nathani			,		Mary	Jane Mc(Jinc	hey		
Maryland	and lam sum		19a. Informant's Name/Relationship				ng Address (Street			•			Code)
2	and ealth m 27		Lee Alice Kimbal	l, Daughte			P Stree	t, N.W.,					20005
OFF	of H If ite		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3	☐Removal from State	Ch 0	ace of Dispo	sition (Name of matory or other plac ce Cremat	e) 	Date) /5 / 04		cation - Ci	-	
Ē	Pag ment ant: lury		4 □ Donation 5 □ Other (Spec		One	sapear ——	de Clemat	ory it	775704	ъет	tsvil	Lie,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or items 23s or 28a-1 show any injury or other traumatic event. The Medical Examiner must be nutified at once.	Į.	21. Signature of Funeral Service Lice) HO	001	10 NOVE	Name and Address app Fune 133 Gist	ral and	Crematic	on Se	rvice	20	910
			23a Part1 Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death	. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	arrest,	,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			cardia	al Infar	otion:					Onset and Death
7	/Medical		resulting in death)	Due to (or as			ir illiai	CLIOII				-	
	Examiner		0 0 0 0 0 0 0	Chro	nic C	bstruc	tive Pul	monary I)isease				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):				_			
	cutec nd ransi	Examiner	that initiated events	c. Alzho	eimer	's Dis	sease						
ó	e exe ian ai ırial-1	Ě	resulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	ficate be executed physician and s the burial-transit	dlcal		d									
9	ntifica ng pl	Wed	IF FEMALE:										
Вох	The law requires that the death certific, tte has been signed by the attending ploage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			2	3d. Date o		
	e dea the at	S	1 ☐ Yes 2 ☐ No	4☐ Pregnant at 9☐ Unknown	time of de	eath 5□	Other (specify)				Month		Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown			M			00 011				
Ś	res the	by	Part II. Other significant conditions	contributing to death b	ut not rest	aiting in the u	ndertying cause giv	en in Part I.					e cause of death?
oro	w requir been si should	ted								Yes 2	1MO 2	☐ Proba	abiy 4 🕅 Unknown
Records,	e law has b je 2 st	Completed							24a. Was	psy	prio	r to com	osy findings available nptetion of cause of
H	(0	S							1 Yes	ormed?	dea 1 🗆		2□ No
Vital	ician: T certificat ector, pa	Be	25. Was case referred to medical examiner?					26. Place of De	ath Check on	one			
of \	ys dir	은	1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatie		ER/Outpatier		4 Xivursing	Home 5 Resi	idence 6	Other	(Specify)
n		00	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wor	</td <td>28d. Describe</td> <td>how injury</td> <td>occurred</td> <td></td> <td></td>	28d. Describe	how injury	occurred		
Sio	Attending r death. ector: After by the fune	cat	2 Accident investigati 3 Suicide 6 Could not	he				Yes 2 □ No					
Division	or Attendated after death	Certification:	4 Homicide determine		ury - At ho c. (Specify	me, farm, str /)	eet, factory, office		28f. Location (City or To		i Number (or Rural	Route Number,
	pital ours a eral [29a. Certifier 1X Certifying	hyeicien. To the bear	of mention	ulados 1 1		- 4-1	4				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		hysician: To the best eminar: On the basis o and manner st	f examinat	tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	curred at the time,	cause(s) a date and	and mann place, and	er as sta due to	the cause(s)
	To the within 2 To the complet	Ř	29b. Signature and title of certifier	/1	.4		29c. Licens						Day, Year)
			reld 4	1 ~	(3		D2	5079		0	ctobe	er 5	, 2004
	1011		30. Name and address of person wh										
-	1271		Dr. Don Yablo	-			e Place,	#502, La	inham, MI	20	706		
N.	Sta Registr		31. Date filed (Month, Pay Year)	32. Begistr	ar's Signa	ture	Sporks						

		Í	1 - State Amend Item 28	State of Maryla 3b&d per me	and / Depa G840 ¿ ē	artment of F	lealth and I Death	Mental Hyg	giene leg. No.2 () ()4 317ne
	Physici		1. Decedent's Name (First, Middle, Last) Chai Lee					2. Date of Dea Month August	20°, 2004	3. Time of Death 6:00 A M
): -	/Medic Examin Funeral		4a. Facility Name (If not institution, give s Holy Cross Nursing 5. Social Security Number 6. Sex	g & Rehab.	vrs. last birthday) 32 Yrs.	Burtonsv	r Location of Death rille If Under 24 Hrs. Hours Min.	1	4c. County of	of Death
	Director		489-74-2019 Usual Residence of Decedent 10a. State 10b. County		SZ Yrs. City, Town or Lo	ocation		Uct. 6,	1921	10d. Inside City Limits
	the Mary 28a-f aho criffied	Director	Maryland Montgomery	Si	llver Sp	ring			10- 0''	1 ∑Yes 2 ☐ No
	s 23a or		10921 Inwood Ave. A	Apt.#136	-110	20904			10g. Citizen of W	
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23a or 28a-f ahow avant, Ire Madical Evarinal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	Ispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Specify:	American Indian, White, etc. Asian
Maryland 21215-0036	filed within 72 ho I Hygiene. other than "natur ant, II a Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bus	
and 2		Be	17. Father's Name (First, Middle, Last) Soon Y. Lee	110.	Condu			ne (First, Middle,		
Mary	and and Is m	To	19a. Informant's Name/Relationship (Ty) Dong Lee- Son	эө, Print)		ng Address (Street		ral Route Number	,	State, Zip Code) MD 20904
altimore,	0 0		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State P	b. Place of Dispo cemetery, crer Parklawn	sition (Name of matory or other place Mem. Par	k 08/2	Date 4/2004	20c. Location - C Rockvill	City or Town, State
Balt	permit, Pag Department Important: I any injury o		21. Signature of Extreral Service License		122	2. Name and Addre	_{ss of Facility} Hir Hampshire	nes-Rina e Ave. S	ldi Fune ilver Sp	eral Home oring, MD 20904
	Physician /Medical		23a. Part1. Enfer the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the die cause on each line. SUBDURA Due to (or as a cons	ic Homp		g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
60,	The law requires that the death certificate be executed as the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a con:			TOWAPPROVED BY	MEDICAL EXAMINE	:R	
(68760	artificate ting physical as the t	Medicai	IF FEMALE:			CERTIFIC	MONAPPINO			
.O. Bo ₂	that the death certiff ed by the attending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time (9□Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	1/	bute to the cause of death? 3 Probably 4 Unknown
Vital Records, P.O. Box		Completed						24a. Was a autops perform	sy pr męd? de	fere autopsy findings available for to completion of cause of eath?
n of Vita	Attanding Physician: The r death. sctor: After this certificate h.by the funeral director, page	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of		er: 4 Nursing H	th (Check only on ome 5 Reside 28d. Describe ho	ence 6 Other	
Division of	To the Hospital or Attanding Phwithin 24 hours after death. To tha Funeral Diractor: Atter th completely filled in by the funeral	Certification:	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, str	M 1 🗆		28f. Location (St.	n State)	r or Rural Route Number, SILUM SEMILE, NO
	ne Hospit n 24 hours na Funera pletely fille	edicai (29a. Certifier 1 Certifying Phys (Check only one) Medical Examir	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	, and due to the carred at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier	- no lone	<u>(</u>	29c. Licens		2	9d. Date signed	(Month, Day, Year) ら, しゃっそ
	/		30. Name and address of person who co	mpleted cause of death ((Item 23a) (Type,	Print)	o covicus, m	0 20852		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature /	Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any njury or other treumatic event. The Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - For State Registrar		Certific	ate of Death	Reg. I	102001	31710
sician	1. Decedent's Name (First, Middle,	Last)				Day Year	3. Time of Death
edical	Peter Lockwood 4a. Facility Name (If not institution,		4h C	ity, Town, or Location of De		5, 2004 tc. County of Dea	
miner	SIII LINDER	WOOD RE		ALTIMOR	E	to. County or Date	
ral	5. Social Security Number		Mont	der 1 Year If Under 24 H		9. Bir	th place (State or Foreignuntry)
tor	216-38-5118 Usual Residence of Decedent	10 M 20 F 8 6	Yrs.				DNITED KING
4	10a. State 10b. County	10c.	City, Town or Location				10d. Inside City Limits
jo	mp	B	ALTIMO	ORE			1 PYes 2 □ N
) irec	10e. Street and Number		10f.	Zip Code	10g. (Citizen of What Co	ountry?
page To Be Completed by Funeral Director	5111 UNDER	5M00D 1	D	21019	UN	ITED K	INGDOM
-une	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	13. Was De	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- arto Rican, etc.)	14. Race - Ame Black, Whit	
by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Ye	s 210 No Specify:		Specify: U	HITE
Completed	15. Decedent's (Specify onfy highest		16a. Decedent's U	Jsual Occupation work done during most of w	odking 16b.	Kind of Business	Industry
mpje	Elementary/Secondary (0·12)	College (1-4or 5+)	life. DO NO	T use retired)	NVC0 (M-N.	001
ပို	17. Father's Name (First, Middle, L	ast)	INSTRU		ame (First, Middle, Maid	an Sumame)	CHL
To Be	FOR STORT TO	WARN IN	KION	D ANING	IF HE	PRIN	3
-	19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Mailing Addr	ess (Street and Number or I	Rural Route Number, City	or Town, State,	Zip Code)
	RITA LOCKUO	OD/SPOUSE	5111 U	NDERLOCE	DRD BF	HIMO	E MD 21
	20a. Method of Disposition 1 □ Burial 2 □ Cremation		p. Place of Disposition (cemetery, crematory)	Name of or other place)	Date 20c.	Location - City or	Town, State
	`4 Donation 5 ☐ Other (Sp.		NATOMYE	11FTS KEG 10	5/04 H	ANOU	ER, MI
Dice	21. Signature of June al Selvice L	icepsee		and Address of Facility augherty Family Funeral	Home And Cremation	Center, P.A.	•
4	23a. Part1. Enter the disea of r	complications that tileed the de		24	d - Pasadena, MD.		Approximate
	shock, or heart failure. List o	only on the se on each line.	eath. Do not enter the r	node of dying, such as cardi	ac or respiratory arrest,		Interval Between Onset and Death
al	disease or condition resulting in death)	a. FND STAGE	DEMENTIA				uses
er				ACE			many
Je	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	SCULAR DTSE.	ASE			1/
Examiner	Cause (Disease or injury that initiated events resulting in death) Last		HEART DISE	ASE EXPERT	ENSIGN		Han
Ü	resulting in death) cast	Due to (or as a cons	- ' - '	DDTOULGGIH AD	DICEACE		. /
edicai	1	dARTERLOSC	CLEROTIC CA	RDIOVASCULAR	DISEASE		
2	IF FEMALE:	23c. If yes, outcome of preg				23d. Date of del	iverv
Physician/	in the past 12 months?	1 Live birth 2 For 4 Pregnant at time of		c pregnancy (specify)		Month	Day Year
hys	9 Unknown	9∐ Unknown					
by P	Part II. Other significant condition	ns contributing to death but not r	resulting in the underlyin	ig cause given in Part I.			the cause of death?
			-		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Junknov
Completed					24a. Was an autopsy	prior to	topsy findings availab completion of cause of
S		-			perfórmed? 1 ☐ Yes 2 ☐		2 No
Be	examiner?	Hospital:		Other	eath (Check only one)	/	
5.		1 □ Inpatient 2	1	DOA 4 INUISING	Home 5 dence 28d. Describe how in	6 ☐Other (Specially occurred	cify)
ij	1 tural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year, ation) Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,	
ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ne 288. Place of Injury - Al	t home, farm, street, fac	tory, office	28f. Location (Street		ıral Route Number,
Certification:	4 D Homeide	building, etc. (Spe	ecny)		City or Town, Sta	110)	
Medical		J Physician: To the best of my k xeminer: On the basis of exam and manner stated.	knowledge, death occur ination and/or investigal	red at the time, date and plaction, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
Mec	29b. Signature and title of certifier	and manner stated.		29c. License number	29d. [ate signed (Monti	h, Day, Year)
	1/1/1/	no	ca-pg1	D08358	00	7.5	2004
	30. N e and address of person w	who completed cause of death (I	tem 23a) (Type, Print)	8902 H	12400	P Par	10
)						,	and the same of th
)	GERITIK	· PATRIC	iV BA	CA. KNA	MICA	up 2	1231
State	31. Date filed (Month, Day, Year) OCT 0 7 200	who completed cause of death (I	gnature	CA. Kra	AUCA	usp 2	1234

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:20 A Lee La 04 /Medical 4a. Facility Name (V not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 905 Dunellen Drive Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2125 Yrs Oct 26, Director 298-22-0046 1926 Ohio Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f show treumatic event, the Medical Examinar must be coulded at 1 ☐ Yes 2 No Director MD Baltimore Towson Pages 1 and 2 should be filed within 72 hours after death with the Nent of Heatth and Mental Hygiene. ent: If item 27 is marked other than "natural", or Items 23a or 28e-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Dunellen Drive 21286 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 25 Married Specify: White 1□Yes 2√No Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ivy Lawrence Wells Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dana LaFon-Strauser/Daughter 1502 Pinnacle Road, Towson, MD 21286 other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Oct 7 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department o Importent: If any injury or Providence U.M. Cem. Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service I Liplus Kolumann M00382 8717 Green Pastures Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ourrest C Dal. manary /Medical Due to (or as a consequence of): Examiner Breast Concer Due to (** s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year signed by the atte in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2 100 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes 2 0 1 Yes 2 No certificate Division of Vital Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 20 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ within 24 hours after To the Funerel Dire filled rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical completely (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 29b. Signaturera 4 (Type, Print) 30 Name and address of person who con (Item 23a) ST, Ballon 32 Registrar's Signature State Dener Registra

DHMH 17 Rev 1/2001

RON 1	E MAUI	TS	BY Please T	ype or Print in Black Inc State of Maryland / Depa			
-			1 - For State Registrar		rtificate of Death		
		***	Decedent's Name (First, Middle, Last)			2 Date of De	ath 3. Time of Death
	Physici /Medi		MYLON &. MO	iw1+3B4		SEPTEM	BER 30, 2004 3:54 P M
}	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death
			1648 WADSWORTH WA		BALTIMORE CITY		N/a
	Funeral Director		216 68 4086	M 2 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da Poul G	9. Birthplace (State or Foreign Country)
	show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary 1-f sh	to	M.D N/a	BA Himo	16		1 Yes 2 □ No
	ith tha Mi or 28a-f	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	ath with tha Maryla 123a or 28a-f shov ust be notified at	rai	1648 Wadsworth	Way	21239		454
36	or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 □×Yes 2 □ No	Was Decedent of Hispanic Origin? (Spet 1 Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
5-0036	72 hours "natural",	led	15. Decedent's Educ	eation 16a. Deced	dent's Usual Occupation		16b. Kind of Business/Industry
21215	ges 1 and 2 should ba filed within 72 hc t of Health and Menlal Hygiene. If item 27 is markad othar than "natur or other traumatic event, the Musical	Completed	(Specify only highest grade	College (1-4or 5+)	kind of work done during most of working NOT use retired) Management of the control of the cont	ng	Penco
	a filed al Hyg otha vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle,	
Maryland	Menta Menta arkad	70	Denor Maritsby		Mangre	ta Ma	acul 1564
Mar	2 sho		19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Rura	l Route Numbe	or, City or Town, State, Zip Code)
	os 1 and of Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	1 3014	20c. Location - City or Town, State
Baltimore,	ages nt of I t: If ite		Burial 2 □ Cremation 3 □ Re	emoval from State cemetery, cren	natory or other place)	/	
Ħ	permit, Page Department o Important: If any injury or once.		' 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	e Loudon 1	ARK 10/5/ Name and Address of Facility	14	Bottome MD
B	perm Depa Impo any i		Tatura Bess	6	29 N. CHENTINE ST		LE 14D 21213
	Dhysisian		Immediate Cause (Final	cations that caused the death. Do not enter a cause on each line.	er the mode of dying, such as cardiac o	r respiratory ar	rest, Approximate Interval Between Operat and Death
7	Physician /Medical-		disease or condition resulting in death)	Due to (or as a consequence of):	Curdiovascular	Diseas	SE
н	Examiner		Constitution of the second				
	ב. ס`	ner	Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects)	Due to (or as a consequence of):			
۷. ۱	be executad ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Busta faces a second of			
60,	be ex ician burial	-53		Due to (or as a consequence of):			
687	phys phys s the	dic	d				
Box (requires that the death certificate been signed by the attending physic nould be detached for use as the b	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month Day Year
P.0	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown			
	res tha igned be del	by F	Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
ord	w require been si should b	ted				1 🗆 Y	es 2 No 3 Probably 4 Unknown
Records,	2 5 0	Completed				24a. Was a autop	sy prior to completion of cause of
al F	Th ate pag					perfor 1 X Yes	med? death? 2 □ No 1 A Yes 2 □ No
Vital		Be c	25. Was case referred to medical examiner?	ospital:	26. Place of Death		
of		. To	Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at		ence 6 Other (Specify) SCHNE
ion	Attending It death. sctor: Aftar	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	or in the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	8f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 XMedical Examin	ician: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the co	cause(s) and manner as stated. state and place, and due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Month, Day, Year)
			Pametet)ou	thall, MD	OCME		OCTOBER 1, 2004
	14		30. Name and address of the who con	mpleted cause of death (Item 23a) (Type, I	Print) 111 Down Ct	+ P-1+	imoro Moraland 21201
	10		Pamela E. Southa		TIL PERI SEIGE	r, Balt	imore, Maryland 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature			

DHMH 17 Rev 1/2001

Registrar

OCT 0 7 2004

			1 - For State Registrer		f Marylan		artmen rtificat			and M		giene Reg. No.		31713
	Physici	an	1. Decedent's Name (First, Middle, Las Pamela Je		aughlin						2. Date of Dea		2004	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give				4b. City.	Town, or	Location of	of Death	ОССОВС		nty of Death	5:00pm м
	Examili	er	1316 Cabello Cou				,.	kesv:		, Douti			rroll	
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.		If Under Months		If Under	24 Hrs. Min,	8. Date of Birti (Month, Day Nov 28,	n v. Year)	9. Birth	place (State or Foreign
	Director		220-48-5999 Usual Residence of Decedent	- W 2 - M	48	Yrs.					Nov 28,	1955	Covi M	D'''
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits
	Mar Hilled	ctor	MD Carroll				Syke	svil:	le					1 □ Yes 2 Ϊ No
	dith th	Director	10e. Street and Number				10f. Zip		,			10g. Citizen USA	of What Cour	ntry?
	eath v	Funeral	1316 Cabello Cou		edent Ever in U.	S 12.1		2178		min? (Cn	acifu Vac ar Na		lace - Americ	non ladina
9	after d		1 Never Married 2 Married	Armed Fo 1 ☐ Yes	rces? 2 XNo	1				, Puerto	ecify Yes or No- Rican, etc.)	I Tal. E	Black, White,	etc.
003	72 hours after death with the Maryland neturel', or liems 23a or 28e-f show dissi Evarthetrnatise Indillisd al	d by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Gir Year or D	ve Pates:		1 ☐ Yes	2tA No	Specify:			Spe	city: Wh:	ite
15-(c * m	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	dent's Usua kind of wor DO NOT us	d Occupa	ation fu <i>ring</i> most	t of work	ing	16b. Kind of	Business/In	dustry
212	withi lene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		erica		,			Socia	al Sec	urity
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yla	should be and Mental marked o umetic sve	L _O	Joseph Lewis			7 10 100 1					ederick			
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumetic	1 15	19a. Informant's Name/Relationship (7 Mr. David J. Lewis		-	1765	Port	er H	ill R	or or Rura Load	a <i>l Route Numbe</i> Annapol	r, City or Tov is, MI	vn, State, Zip) 2140:	l Code)
lore,			20a. Method of Disposition 1 🗆 Burial 2 🏋 Cremation 3 🗀		State 20b. P	Place of Dispo emetery, crer	sition (Nan natory or o	ne of ther place	⁵Srv.		Date		n - City or To	
Itim	그 돈 돈 글 .		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen	-	A1:	1 Coun			-				ville,	
Ba	Depa Impo eny ir		Buand	Hay	G	S	ykesv	ille	, MD	2178	E & CHAP 84 (410)	-795- 1	1 (Box 1400	195)
Н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that one cause on e	aused the death	n. Do not ent	er the mod	e of dying	g, such as	cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	(or as a conseq	st 1	on	con						STEARS
П	Examiner			Due to	(or as a consequ	uence or):								
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9	rtificat ng ph) as th	Medi	IF FEMALE:											
Вох	death certifica attending ph d for use as th	lan/I	23b. Was decedent pregnant in the past 12 menths?	1 Live b	tcome of pregna pirth 2 Teta	Ideath 3□	Ectopic pr					-	Date of delive	ery Day Year
o.	that the de ed by the a detached t	Physiclan/Medi	1 ☐ Yes 2- No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of do own	eath 5L	Other (sp	ecity)						,
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ord	w requires t been signe should be	eted									1 U Y	- \		ably 4 Unknown
Records,	The law ate has t page 2 s	Completed									24a. Was a autop	SV.	b. Were auto prior to con death?	psy findings available mpletion of cause of
Vital		a	25. Was case referred to medical						26 Place	of Death		20 No	1 🗌 Yes	2 No
of Vi	ysic is ce direc	To B	examiner? 1 Tes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 🗆 DO	A Othe			me 5 Resid		Other (Specifi	sisters
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injury Work		100	28d. Describe h	ow injury occ	urred	Home
Division	or Attending after death, Director: After in by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho	ome, farm, str	M eet. factory		res 2□1	-	28f. Location (S	treet and Nu	mber or Rura	l Route Number.
Div	i Zit e	Certification;	4 Homicide	build	ing, etc. <i>(Specif</i>)	y)	oot, lastory	, 011100			City or Tow	n, State)		. 110010 11011001,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exert	iner: On the b	e best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, th occurr	and due to the c ed at the time, c	ause(s) and late and plac	manner as st e, and due to	ated. the cause(s)
	To t Withi To tl	W	29b. Signature and title of certifier	RAN	in		290	^	number 3092	5	2	9d. Date sig	ned (Month,	Day, Year)
			30. Name and addies s of person who o	completed caus	se of death (Item	1,23a) (Type,	Print)					17/7	100	~(
	10		Aud (Plano 31. Date filed (Month) Day, Year)	6569	N. (Registrar's Signa	hurle	05	T:	#209	5 6	ALTM	one, v	02	1204
	Sta Registi		OCT 0 7 201	14	SAL X	" Ap	w							-

		ĺ	1 - For State Registrar		of Marylar		artmen tificate				F	Reg. No.	Acceptance of the second of th	31714	
+	Physici /Medic Examin	al	Decedent's Name (First, Midde 2 Be Aa. Facility Name (If not institution)	on, give street and nu				Town, or	Location of	C	Date of Dea Month	Day 2 03 4c. Co	ounty of Death		_
	Funeral Director		5. Social Security Number 578-42-7848	6. Sex/	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	Date of Birt (Month, Day	h /, Year)		place (State or Foreign intry)	-
	with the Maryland e or 28e-f show	ctor	Usual Residence of Decedent 10a. State 10b. Count Maryland	y Howard	10c. Ci	ty, Town or Lo	cation		≣lkridge	e				10d. Inside City Limits 1 ☐ Yes 2 ☐ 10	_
	th with the 23e or 28	ai Director	10e. Street and Number 7925-K Briarglen	Drive			10f. Zip	Code	21	075		10g. Citizer	n of What Cou U.S	intry? S.A.	
920	or Itams	by Funerai	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 X es	2 □ No	1050	Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)		Race - Amer Black, White pecify:		
21215-0036	filed within 72 hours Hygiene. ther than "natural", int, the Madical Exi	Completed		est grade completed College) (1-4or 5+)	(Give	DO NOT us	rk done d se retired	uring mos	t of working visor		16b. Kind	of Business/li insu	ndustry Irance	
Maryland	d tale	To Be C	17. Father's Name (First, Middle George	o, <i>Last)</i> ge Albert Marl	owe				٠			ys Hope	Conner		
	and 2 sho saith and n 27 is m er traum		Ms. Lucille C. Ma		Spouse		7925-K	Briarg		e Elkrid	ge, Mary	land 21			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or other traumatic. <u>once.</u>		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other		n State	Place of Dispo cemetery, crer Maryland	natory or o	ther plac		10/0	e 7/2004		tion - City or T Crownsville	own, State e, Maryland	
Balt	permit. Departr Importa any inju		Signature of Furieral Service	111	MODS IS	22	2. Name an S	Slack F	uneral	Home.	P.A. ke Ellico	t City. N	ИD 21043		
	Pnysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li fimmediate Cause (Final disease or condition resulting in death)	st only one cause on	ceused the dea each line.	nia								Approximate Interval Between Onset and Death	
1760,	Example of executed with the burial-transit of the burial-transit	icai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	Ependo (or as a consec	LCU quence of): YMC	dy	sph	agio	2				3years	
P.O. Box 68	ath certific ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	utcome of pregn birth 2 Feta gnant at time of a nown	al death 3[Ectopic pr					230	d. Date of deliv Month	very Day Year	
	w requires that the debeen signed by the a should be detached f	by	Part II. Other significant condi	tions contributing to		sulting in the u	nderlying c	ause give	en in Part I			obacco use		the cause of death?	
of Vital Records,	ding Physician: The law ra n. After this certificate has be funeral director, page 2 sh	Completed									1□ Yes	rmed? 2 No	24b. Were aut prior to co death?	opsy findings available ompletion of cause of	
of Vita	Physician this certifi al director	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	inpatient 2	ER/Outpatier	_		er: 4 □ Nu	rsing Home		lence 6	Other (Speci	fy)	
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Divi	To the Hospitel or Attend within 24 hours after death To tha Funerel Director: completely filled in by the		4 Homicide dete	mined 286. Plac	ce of Injury - At h ding, etc. (Speci	ify)					City or Tow	m, State)		al Route Number,	
	ne Hosp n 24 hou ha Fune oletely fil	Medical		ring Physician: To the al Examiner: On the and ma											
	To the within 2 To tha comple	Σ	29b. Signature and title of certification	TD			290	DG. License	number 033	0			igned (Month)	Day, Year)	
	1.0		30. Name and address of person REGINA OSIH	a utra completed on	use of death (Ite	m 23a) (Type, AUE	Print)	KOH	A PA	PK				/	_
	St Regist	ate rar	31. Date filed (Month Day, Yea	2004 32.	Degistrar's Sign			nds.							

			For State Registrar	State of Man		epartmen Certificat				giene 10g. No.		31715
ì	Physicia /Medic		1. Decedent's Name (First, Middle, Las GWENDOLINE ANGE:						2. Date of Dea Month Septemb	er 29	2004	3. Time of Death 11:00P M
>	Examin		4a. Fecility Name (If not institution, give					Location of Death			ty of Death	
	5		Hillhaven Assist		n yrs. last birth			Spring If Under 24 Hrs.	8. Date of Birt	<u></u>	tgome	
	Funeral Director			T.F		rs. Months	Days	Hours Min.	Dec. 04	1909	Sout	place (State or Foreign intry) h Africa
	pur *	Ì	Usuel Residence of Decedent 10a, State 10b, County	10	Oc. City, Town	or Location						10d. Inside City Limits
	Maryla f sho	5	Maryland Montgom			r Sprin	σ					1 K Yes 2 No
	r 28a-	Directo	10e. Street and Number			10f. Zip				10g. Citizen of	What Cou	ntry?
	th with		407 Quaint Acres	Drive		2	0904			Unite	d Kin	gdom
5-0036	72 hours after death with the Maryland "naturel", or flems 23e or 28e-f show olical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 👺 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	13. Was Deced If Yes, spec		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ice - Ameri ack, White, ify: Wh	, etc.
2-0	72 hours "naturel",	eted	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. I	Decedent's Usua (Give kind of wo	rk done d	luring most of work	ina	16b. Kind of E	dusiness/Ir	idustry
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d 21	be filed withir tal Hygiene. d other than event, the M	e Co	17. Father's Name (First, Middle, Last)	2 Years		Denoor	Teac	18. Mother's Name	e (First, Middle,			
a	Q to D	To Be	Evelyn Tarr					E11en	Amelia	Dubbe	r	
Maryland	2 should and Market the market	Γ.	19a. Informant's Name/Relationship (and Number or Rur				
	s 1 and 2 should if Health and Mer item 27 is marks other traumatic		Halketh L. Marter					res Drive	, Silve			
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Balt	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licer	e cent	· ~e	22. Name an HINES-1 11800 N	d Addres RINAI New I	s of Facility LDI FUNER Lampshire	AL HOME Ave, S	INC.	Spring	g, MD 20904
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ALZ		ERIS	01	SEASE				S Y CARS
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ó	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a c	onsequence o	f):						
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9			IF FEMALE:	23c. If yes, outcome of	nregna nev				- 17-110			
D. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live birth 2 (4 Pregnant at tirr 9 Unknown	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp					ate of deliver	ery Day Year
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rds	w requires been sign should be	ed by							1 🗆 Y	es 2⊠No	3 🔲 Prot	bably 4 Dunknown
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ta	ician: The certificate harector, page	a	25. Was case referred to medical					26. Place of Deatl	1 Yes	22 No	1 🗆 Yes	2 No
<u>=</u>	nysician: nis certific director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Out	patient 3 DC	Othe				her (Specil	_(y) Assisted
0	ding Phy h, After thi funeral d		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Ti	me of 2	8c. Injury Work		28d. Describe h			Living
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<u>></u>	al or A s after il Direct	Certification:	4 Homicide determined	building, etc. (Specify)	m, street, ractory	, once		City or Tow		Der Gr Aura	u noute number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical (29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of r niner: On the basis of ex and manner stated	amination and	death occurred Vor investigation,	at the tim , in my op	e, date and place, inion, death occur	and due to the c	cause(s) and m date and place	anner as s , and due t	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1211			. License			29d. Date sign		
,	4) Culli	100000			VOC	31563	C	CTOBER	5,	2004
_	4		30. Name and address of person who CHARLES M. BEN	NER MD	10801	Type, Print)	טט ס	12 NE#20.	SILV	ERSIR	1145	20901
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	9 1	Popul	W				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 6 Day 2004 Year **Physician** 0607 Edith Marie McGrath /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Bel Air Upper Chesapeake Medical Center 8. Date of Birth Sept. 26, 1927 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Wouldy. 1□M 2□F Yrs. Director 215-24-4633 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other traumatic event, the Medical Examinar must be nutified at Forest Hill 1 ☐ Yes 2 ☐ No Harford Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21050 400 Forest Valley Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married white ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Is marked o Vita Cross Roy McLaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3501 Beach Road, Middle River, Md. 21220 Health item 27 I Gary Houck/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Importent: If its any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 10/8/2004 Timonium, Md. ° 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YOCARDINI INFARC Priysician disease or condition resulting in death) /Medical EREBRO-VASCUAR ACCIDET Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HROMOEMBOLIC EVENT for use as the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PNEUMOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation Natural

death certificate be executed ed by the a o. Hospital or Attending Director: 24 hours after Funerel Direct

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

or 28e-f show

Items 23a

"natural".

Medical

2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

29a. Certifier

1 🗌 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

PHYSICIAN

32. Registrar's Signature

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IPPER CHESAPEANE

BEZ

State Registrar

npletely

within 2. To the

State Registrar 31. Date filed (Month, Day, Year)

OCT 07 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vaar **Physician** KEVIN MICHAEL MUNLEY October 4. 2004 2:55 P /Medical 4a, Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 127 Jamestown Road Apt. Ocean City Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours Min Months XX M 2□ F 213-60-6316 51 Director 03-18-1953 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at MD. WORCEST ER OCEAN CITY 1 ☐ Yes 2 X Xio Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 127 JAMESTOWN ROAD, APT. F 21842 U. S. A. or Items 23e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXINo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: WHITE þ Specify. 3 Widowed 4XXDivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT WAITER YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MICHAEL FRANCIS MUNLEY JACQUELINE A. ROUCHARD 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13902 SAILING ROAD, OCEAN CITY, MARYLAND, 21842 JACOUELINE M. FIELDS (MOTHER) other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it eny injury or o 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 10-07-2004 TOWSON, MARYLAND, 21204 4 □ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Complications of chronic alcoholism /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physicien: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day ò in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Dunknown Completed Were autopsy findings available prior to completion of cause of death?
 ™ Yes 2 □ No 24a Was an certificate has autopsy performed? 1X Yes 2□ No of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA at scene 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Division or Attending 5 Pending investigation 1XX atural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide filled Hospitel 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 111 Penn Street, Baltimore, Maryland 21201 Ana Rubio, MD

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 7 2004

32. Registrar's Signature

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			For	State of Maryland	•		Mental Hyg	iene	0:310
			State Registrar		Certifica	te of Death		eg. No.	31/19
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	Director		212-60-1842 Usual Residence of Decedent	64			March 1	3 194Ψ	
	anylan show	_	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits 1,☐ Yes 2 ☐ No
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36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importent: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show amply injury or other traumatic event. I've Medical Examinar must be notified at once.	by Fu	1 Never Married \$\text{Married} 3 \text{Widowed} 4 \text{Divorced}	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		2 □No Specify:	, 5,5.7		Black
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			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	Mysal Co.	-1	1 Anna	polis, 40
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal		MIYELL CO	enrano	00, 21	701
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Important: if any injury o once.		21. Signature of Funeral Service Licer	22. I	Name and Address of Facility	PARY P Ma	rch Fun	eval Hon
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gned by the attending I be detached for use as by Physician/Me		23b. Was decedent pregnant in the past 12 months?		ctopic pregnancy		23d. Date of delive	•
by the at tached for hysici		1 Yes 2 No	4□Pregnant at time of death 5□C	Other (specify)		Month	Day Year
detacl			ontributing to death but not resulting in the und	eriving cause given in Part !	23e Did tobacc	o use contribute to	the cause of death
			ATITIS C	shying daddo given in r air i.		2 □ No 3 □ Pro	
	-	CIM TO THE			•		
hould					24a. Was an autopsy performed	prior to co	opsy findings avail ompletion of cause
hould	-					4 🗆 1	OBS N-
hould		26. Was case referred to medical			1 ☐ Yes 21 ☐	No 1 ☐ Yes	2 DS NO
ertificate has been si sctor, page 2 should Be Completed	2	25. Was case referred to medical examiner? 1 □ Yes 2 N No	Hospital: 1 1 Innation 2 FR/Outnation		1 ☐ Yes 2 ☐ eath (Check only one)		
his certificate has been si I director, page 2 should To Be Completed	2	examiner? 1 ☐ Yes 2 5 No 27. Manner of Death	28a. Date of Injury 28b. Time of	3 ☐ DOA Cther: 4 ☐ Nursing	1 ☐ Yes 21 ☐	6 □Other (Spec	
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 1 Yes 2 No 17. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	3 □ DOA Cther: 4 □ Nursing	ath (Check only one) Home 5 ☐ Residence	6 □Other (Spec	
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, stree	ODA Cther: 4 \sum Nursing 28c. Injury at Work? M 1 \sum Yes 2 \sum No	ath (Check only one) Home 5 Residence 28d. Describe how in	6 □Other (Specially occurred	ify)
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 1	28a. Date of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	Cther: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No 1, factory, office	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Str	6 □Other (Speciality occurred and Number or Rurate)	ify) ral Route Number,
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not b determined 4 Homicide 10 Certifying Ph	28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	Cther: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No I, factory, office	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St.	6 Other (Specializer) 6 Other (Specializer) 6 Other (Specializer) 6 Other (Specializer) 6 Other (Specializer)	ral Route Number,
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 1	28a. Date of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	Cther: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No t, factory, office ccurred at the time, date and place stigation, in my opinion, death occurred.	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street on the cause curred at the time, date as	6 Other (Specializer) and Number or Rurate) (s) and manner as and place, and due to	ral Route Number, stated. to the cause(s)
el Director: After this certificate has been si ed in by the funeral director, page 2 should Certification: To Be Completed	2	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Place of Injury - At home, farm, stree building, etc. (Specify) 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No t, factory, office	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street at the time, date at the time, date at 29d. I	6 Other (Specializer) occurred and Number or Rurate) (s) and manner as and place, and due to the place of t	ral Route Number, stated. to the cause(s) Day, Year)
er this certificate has been sineral director, page 2 should T. To Be Completed	2	examiner? 17 Yes 2 No 27 Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not b determined 29a. Certifier (Check only one) 2 Medical Examine) 29b. Signature vid title of certifier	28a. Date of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, stree building, etc. (Specify) 28c. Place of Injury - At home, farm, stree building, etc. (Specify) 28c. Place of Injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No t, factory, office cocurred at the time, date and place stigation, in my opinion, death occurred.	eath (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St.	6 Other (Special Special Speci	ral Route Number, stated. to the cause(s) Day, Year)
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		1 - State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygier	711116	31722
Physici /Medic		1. Decedent's Name (First, Middle, Last) Denise Ann O'Hare		2. Date of Death	^{Day} 2004 Year	3. Time of Death 3:00cm M
Examin		4a. Facility Name (If not institution, give street and number) 6222. Radeckee Avenue	4b. City, Town, or Location of Death Baltimore, MI If Under 1 Year If Under 24 Hrs.			
Funeral Director		5. Social Security Number \$\frac{1}{2}\text{19-62-2645}\$ Usual Residence of Decedent 6. Sex 1 \sum M 2 \subseteq F 7. Age (In yrs. last birthday 44 Yrs. 44 Yrs. 44 Yrs. 45 Yrs. 46 Yrs. 47 Yrs. 47 Yrs. 48 Yrs. 48 Yrs. 48 Yrs. 48 Yrs. Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Yel 09/18/19		lace (State or Foreign try)
Maryland -f show list at	tor	10a. State MD 10b. County Baltimore 10c. City, Town or L	ocation Baltimo	are MD	1	0d. Inside City Limits
with the 3a or 28a	Funeral Director	10e. Street and Number 6222 Radecke Avenue	10f. Zip Code 21206	10g.	Citizen of What Cour	ntry? d States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or thems 23a or 28a-1 show any injury or other traumatic event, It a Medical Examination to other traumatic event, It a Medical Examination to other traumatic event.	by	11. Marital Status 1 XX ever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX or large year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medicul Exam	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) Office Assistant	16b.	Kind of Business/Inc	
and illection in the control of the	To Be C	17. Father's Name (First, Middle, Last) John O'Hare		(First, Middle, Maid e Kuclej		•
y, Maryla and 2 should ealth and Men n 27 is marke ier traumatic	1	19a. Informant's Name/Relationship (<i>Type, Print</i>) Janice: Vance / Friend	ing Address (Street and Number or Rura 6222 Radecke Avenue, B		y or Town, State, Zip ID 21206	Code)
altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or othe		'4 □ Donation 5 □ Other (Specify) Holy Cross	ematory or other place)		Location - City or To	
Balt permit. Depart Importa any inji		21. Signature of Funeral Service Licensee Victor P. Doda, Jr.	2. Name and Address of Facility Farles L. Stevens Fune 1501 Fast Fort Avenue,	ral Home, Ir Baltimore N	nc. Yaryland 212	230
Medical Examiner physician and the purial-transit the purial-transit	dlcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. C. C. C. C. C. C. C. C. C. C. C. C. C	overload equisions			Interval Between Onset and Death
the death certific the attending p the attending p ched for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
Cords, P. w requires that been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to th	e cause of death? ably 4 Unknown
	Completed			24a. Was an autopsy performed 1 Yes 2 X	prior to con death?	osy findings available inpletion of cause of 2 No
Division of or Attending Physafter death. Director: After this in by the funeral di	Certification; To Be	25. Was case referred to medical examiner? Yes 2 No	of 28c. Injury at 2 Work? M 1 Yes 2 No	ne 5 Residence 28d. Describe how in	jury occurred and Number or Rura	,
he Hospital n 24 hours a he Funeral	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as stand place, and due to	ated. the cause(s)
To the Ho within 24 To the Fu complete!	Me	29b. Signature and title of certifier Farty Waterbury, M. D	29c. License number	10	Date signed (Month, D	
13			Print) 10 EASTERN AUE.,	BALT. LIL	0. 21229	4.
Sta Registr		31. Date filed (Month, Day, Year) OCT 0 7 2004 32. Registrar's Signature	pale			

			4 101	partment of Health and Mertificate of Death		giene	31723	
I	Physici		Decedent's Name (First, Middle, Last) Ruth M Pritchard		2. Date of Dear Oct 1	Day 2004 Year	3. Time of Death 3. 40 A M	
>	/Medic Examir		4a. Facility Name (If not institution, give street and number) Bayview Hospital	4b. City, Town, or Location of Death Baltimor		4c. County of Dear		
Ì	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 XF 75 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day May 13	9. Birl	hplace (State or Foreign ountry) StVirginia	
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Baltimore Balti			10d. Inside City Lim 1 ☐ Yes 2 🔀 t		
	3s or 28s	al Director	10e. Street and Number 8051 Bank Street	10f. Zip Code 21224		0g. Citizen of What Co	buntry?	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Exertified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.	
Maryland 21215-0036	within 72 ho liene. r than "natur the Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) Sial Worker	ng	16b. Kind of Business, State of		
/land :	b d la	To Be C	17. Father's Name (First, Middle, Last) Dillard McNeely	18. Mother's Name Gertie				
	2 sh and 1s m		19a. Informant's Name/Relationship (Type, Print) 19b. Mai Debra Lynn Seamster/daughter 6	ling Address <i>(Street and Number or R</i> ura 5231 East Encant				
Baitimore,	Jes 1 of Hi If Iter or oth		20a. Method of Disposition **X Burial 2 Cremation 3 Removal from State **4 Donation 5 Other (Specify)	ematory or other place)		20c. Location - City or Baltimore		
Balt	permit. Pag Department Importent: I any injury c		K. Jury Connelly	22. Name and Address of FacilityCon 300 Mace Ave.	Baltim	ore MD 21	neofEssex 221	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not explose, or heart failure this only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac of Bowel Suspension	r respiratory arre	est,	Approximate Interval Between Onset and Death	
8/60,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, in the Later Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
O. Box 6	ath certif ttending or use a:	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	very Day Year	
cords, P	quires that the de n signed by the a ald be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the Record fewer Sch	underlying cause given in Part I. George HTN		pacco use contribute to	the cause of death?	
E E	The taw require sate has been signage 2 should b	Completed	ASCVD' Anomia, O	Dreopororis	24a. Was a autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of	
VITAI		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death	Check onl on			
lon of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	atlon: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation			w injury occurred	iny)	
DIVISION	tel or Atters a after de el Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town	reet <i>and Number or Ru</i> i, <i>State)</i>	ral Route Number,	
	the Hospi in 24 hour the Funer pletely fill	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurred	and due to the ca ed at the time, da	luse(s) and manner as ate and place, and due	stated. to the cause(s)	
	To To Corr	2	29b. Signature and title of certifier M.D	29c. License number D-3875	4	ed. Date signed (Month	2004	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type MALIKA WASEGM. 709.	3ASTERN BLV	D. 1	MD - 21	221.	
:	Sta Registi		31. Date filed (Month, Day, Year) 33. Registrar's Signature (Sporks!				

			State of Maryland / Department of Health a 1 - State Registrar AMEND ITEM #20b PER FH G836e161607609 DEath	and Mer		ene . 🔐 () () ()	31724
		44	1. Decedent's Name (First, Middle, Last)		Date of Death	Day Yeer	3. Time of Death
Н	Physicia /Medic		THOMAS LEE PAYNE	OC	Month	2, 2004 ^{er}	7:50P. M
	Examin	er	4a. Fecility Name (If not institution, give street and number) SINAI HOSPITAL 4b. City, Town, or Location of BALTIMORE	of Death		4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs. 9	Date of Birth	N/A	place (State or Foreign
	Funeral Director		1 → 2 F 5 2 Yrs. Months Days Hours	Min.	(Month, Day, Y	ear) Cou	RGLNTA
-			Usual Residence of Decedent	101	U112 U.g.		
	show		10a. State 10b. County 10c. City, Town or Location 10c. Ci				10d. Inside City Limits 1 X es 2 No
	Ba-f s	Director			-T		E1
	with the la or 2	Dire	10e. Street and Number 10f. Zip Code 21215		"	Citizen of What Cou	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinant must be multified at once.	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give 1 Yes, specify Cuban, Mexican 1 Yes, Give 1 Yes, Specify Cuban, Mexican 1 Yes, Give 1 Yes, Giv	n, Puerto Rici	y Yes or No- an, etc.)	14. Race - Ameri Black, White	, etc.
21215-0036	Phour	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16	b. Kind of Business/Ir	
212	hin 72 e. en "na Madi	plet	(Specify only highest grade completed) (Give kind of work done during mos life. DO NOT use retired)	st of working			
	ed wit ygien eer th	Con	12TH UNKNOWN CEMENT FINISHER			ONSTRUCT	ION
Maryland	be fill tal H d oth even	Be			îrşt, Middle, Ma	iden Sumame)	
2	hould d Mer marke matic	ဥ	THOMAS LEE PAYNE, SR. UNKN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)	NOWN per or Bural Bo	oute Number. C	City or Town, State, Zi	a Codel 2 1 2 1 E
Ma	Ith an 27 is i		LETHA PAYNE (WIFE) 3034 OAKFORD AVE			MORE, MAR	
Baltimore,	ges 1 ar t of Hea If item or othe		20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State	10/9 7%) 4 Å	ŔĸŨĬŨŜŸ°,	MARYLAND
Ħ	artmen ortant: njury		21 Signature of Funeral Service Licensee 22. Name and Address of Facility	10/9/0			
Ba	Depar Depar Impo		LEWIS T. GWYNN LEWIS T. GWY	YNN FU	UNERAL		1215
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or re	espiratory arrest	E BALTO	proximate Interval Between
N	Priysician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical		resulting in death) a				
Н	Examiner	l, l	Sequentially list conditions. b				
	ed Isit	Examiner	if any, leading to immediate Due to (or as a consequence or): Cause (Disease or injury)				
•	cate be executed physician and the burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	e be e	dlcal	d				1002
89	tificati g phy as the	ledle					
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of deliv Month	very Day Year
Δ.		by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	I.	23e. Did tobac	cco use contribute to	the cause of death?
rds	w require been sig should b				1 🗆 Yes	2 No 3 □ Pro	bably 4 Unknown
I Records,	e la has	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
Vital	i cian : Th certificate rector, pag	Be (examiner?	e of Death (C	Check only one)		
of \	d s	မ				ce 6 Other (Specialistics)	ity)
		lon	27. Manner of Death Natural 5 Pending (Month, Day Year) Natural investigation 28a. Date of Injury 28b. Time of 28c. Injury 28c. Injury 28c. Injury 28c. Injury 38c. Injury 28c. Injury 28c. Injury 28c. Injury 38c. Injury		I. Describe how	injury occurred	
Division	l or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not be			et and Number or Rui	ral Route Number,
<u>S</u>	in Die	erti	4 Homicide building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attenwihin 24 hours after deall to the Funeral Directors completely filled in by the	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, dead and manner stated.				
	To the within To the	Me	29b. Signature and title propertities 29c. License number		29d	I. Date signed (Month	Day, Year)
	(1.		0.C.M.	.E.	O	CTOBER 3,2	004
	K		30. Name and ddress of person who completed ausr of eath (Item 23a) (Type, Print) 111 Penn Street	et, Bai	ltimore	, Maryland	21201
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist		OCT 0 7 2004 Bendera & Sparker				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of N	Maryland / Depa		of Health of Death	•	giene Reg. No. () (Second	725
	Physici /Medio		1. Decedent's Name (First, Michael Fatricia	Putman	•			2. Date of De	27 c	2004 /	942 M
	Examir 	er	4a. Fecility Name (If not institute HO' 5. Social Security Number	ward County Gene		If Under 1 Y		Columbia 24 Hrs. 8. Date of Bir	4c. County	of Death Howard 9. Birthplace (Sta Country)	ate or Foreign
	Director		213-90-4942 Usual Residence of Decedent	1□M 2XF	37 Yrs.	Months D	ays Hours	Min. (Month, Da		Country) Maryl	
	laryland show		10a. State 10b. Cour	ity	10c. City, Town or Lo	ocation					le City Limits
	se-fsl	Funeral Director	Maryland	Howard			Elkridg	e		1 🗇	Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Co		075	10g. Citizen of W	vhat Country?	
	death	nera	8065 Hillrise Cou	12. Was Deceder	nt Ever in U.S. 13.	Was Deceden		igin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race	- American India	n,
5-0036	72 hours after death with the Maryland naturel', or tiems 23a or 28a-f show Acal Examiner must ban allified at	þ	1 Never Married 2 M 3 Widowed 4 Divorc	If Yes Give	No	~	No Specify:		Specify	k, White, etc. : White	•
21215-0	- 1	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education nest grade completed)) College (1-4o	(Give	dent's Usual O kind of work o DO NOT use r	done during mos	t of working	16b. Kind of Bu	siness/Industry Accounting	
	2 should be filled withir and Mental Hygiene. Is marked other than aumatic evant, the M.	Col	17. Father's Name (First, Middle	e, Last)			Accountar 18, Moth	nt er's Name (First, Middle,	Maiden Sumam	e)	
lan	uld be fental rked o	To Be		ewis N. Sledge					iomi H. Hay	,	
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relatio	nship (Type, Print)	19b. Maili	ng Address (Si	treet and Numb	er or Rural Route Numbe			
	1 and Health em 27		Mr. Eric Putn 20a. Method of Disposition	nan Husb	and Sob. Place of Dispo			kridge, Maryland		City or Town, Stat	
mor	Pages ent of nt: If it ry or o		~ /	n 3 Removal from Stat	- comptont are	natory or othe	r place)	2-1-04 1	2011	= ca N	· ^
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Savid		3 Page 25	Sla	ddress of Facili ck Funeral	Home, P.A.	per in i	OIE, IV	10
			23a. Part1. Enter the dis as shock, or heart failu	mplications that cause on each	ed the death. Do not ent	387	'1 Old Coli.	mbia Pike Ellicet	tt City, MD 2 rest,	Approxi	mate Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Me	tastatic	una	can	cer			ind Death
	/Medical Examiner		resulting in usually	Due to (or a	s a consequence of):					1	
	7 -	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (una	s a consequence or;						
	ecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or a	s a consequence of):						
8760,	cate be executed oblysician and the burial-transit	icai E		d	a consequence or,						
O. Box 6	ath certifii titending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregn Other (specif		***	23d. Date Mon	e of delivery oth Day	Year
<u>α</u>	w requires that the de been signed by the a should be detached t	by	Part II. Other significant cond	tions contributing to death	but not resulting in the u	nderlying caus	e given in Part I	23e. Did to		bute to the cause	
Il Records,		Completed							rmed2 pi	/ere autopsy findir rior to completion eath? □ Yes 2 □ No	ngs available of cause of
of Vital	Physician: The this certificate ral director, pag) Be	25. Was case referred to medie examiner?	Hospital:			04	of Death (Check only o			
l of	4d tale	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of In	jury 28b. Time of		lnjury at Work?	rsing Home 5 Resid	lence 6 Othe low injury occurre		
sion	Attending F r death. ector: After by the funer	atio	2	stigation	lay Year) Injury		1 Yes 2	No			
Division	tal or Att s after d al Direct ed in by t	Certification;		mined 286. Place of I	njury - At home, farm, str atc. <i>(Specify)</i>	eet, factory, of	fice	28f. Location (S City or Ton		r or Rural Route N	lumber,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certify (Check only 2 Medic	ring Physician: To the bes al Examiner: On the basis and manners	of examination and/or in	occurred at the vestigation, in the	he time, date an my opinion, dea	d place, and due to the o th occurred at the time, o	cause(s) and man date and place, a	ner as stated. nd due to the caus	se(s)
)	To t.	Σ	29b. Signature and ottle of certification	lier AD		7 -	cense number	-	Sent	(Month, Day, Yea 29	i
	15		30. Name and address of person	on who completed cause of	death (Item 23a) (Type,	Print) Print)	torent	Pews C.	lumbia	MD	1
	Sta Registr		31. Date filed (Month, Day, Yea OCT 0 7 20		trar's Signature	south!	ituxent	1134	10111111111		
				/	1 17	was					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For State Registrar	State of Marylar	-	artment of Healt rtificate of Dea		lygiene Reg. No. 0	4 31726
1	Physici /Medic		1. Decedent's Name (First, Middle, La Joan Charlotte I	Pearson			2. Date of Month Octo	ber 3, 200	
F	Examin uneral irector	er	4a. Facility Name (If not institution, giv Upper Chesapeake 5. Social Security Number 6. S 229-34-6398	Medical Cent		4b. City, Town, or Location Bel Air If Under 1 Year If Unit Months Days Hour	der 24 Hrs. 8. Date of (Month,	Birth Say, Year)	ford Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo		July	22, 1933	10d. Inside City Limits
deeth with the Maryland	a or 28a-f show Lbe notified at	Director	Md. Harfo			Abingdon 10f. Zip Code 2100	9	10g. Citizen of Wh	1 □ Yes 2x No mat Country? ed States
9	al', or Items 23 Examiner mus	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic f Yes, specify Cuban, Mex 1 ☐ Yes 2 ☐ No Spec		No- 14. Race -	American Indian, White, etc. White
1215 -within 72	r than "natural", the Medical Exa	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5+)		dent's Usual Occupation kind of work done during n DO NOT use retired) DOTATOTY ASS		16b. Kind of Busi	
/land 2 uld be filed	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic avent, If 2002.	To Be Co	12 years 17. Father's Name (First, Middle, Last) Nicholas Joseph				other's Name (First, Mide argaret M.		
Mary Id 2 sho			19a. Informant's Name/Relationship (Randall Bright/s			g Address (Street and Nui Federal Gar			
Baltimore, Dermit. Pages 1 an			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State	Place of Dispo	sition (Name of natory or other place) n Nat'l Cem.	Date	20c. Location - Ci	ty or Town, State
Balt permit. Departr			21. Signature Fund 1 Agrice Licer 23a. Part1. Enter the disease, or comshock, or heart failure. List only			Name and Address of Fa Schimunek 610 W. Mac	Funoral Hom	e of Bel A Bel Air.	ir, Inc. Md. 21014
/Me Exa	sician and as the private state of the private stat	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d.	quence of):	diel Onfu - Vasculi	La Deser	د	Onset and Death
Box	ed by the attending pr detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 150 No. 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	
CO S	been signed b	by	Part II. Other significant conditions of	ontributing to death but not res					ute to the cause of death?
I Rec	ate has page 2	Completed					pe	topsy prio rformed2 dea	re autopsy findings available ir to completion of cause of th? Yes 2 \(\text{No} \)
Name >	0 0	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient	04	ace of Death (Check only Nursing Home 5 Re		(Specify)
Division of or Attending Praffer death.	After	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2	28d. Describ	e how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division To the Hospital or Attendity within 24 hours after death	illed in by		4 Homicide determined	building, etc. (Specif	fy) 		City or 1	own, State)	or Rural Route Number,
To the Hospital within 24 hours a	the Fun	Medicai	one)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my opinion, d	leath occurred at the time	e, date and place, and	due to the cause(s)
To	2 0		29b. Signature and title of certification	to no		Doo 3	6487	29d. Date signed (A	oif
	3		30. Name and address of person who of D2 Steven	completed cause of death (Item Bentman		erint)	6487 henrowske	mediel	Center
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	land			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 October Philip P. Palmere 3:05 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Churchville 1228 Glenview Court If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5, 1934 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Days 1□ M 2□ F Director 70 216-30-6292 Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Harford Churchville 1 ☐ Yes 2 Ho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Items 23a 1228 Glenview Court 21028 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 50 Specify: white 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene. auditing tax auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony P. Palmere Agnes Jednoralski ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alda J. Palmere/wife 1228 Glenview Court, Churchville, Md. 21028 20b. Place of Disposition (Name of cometery, crematory or other place)
Holy Trinity Epis. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 10/6/2004 Churchville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bny Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 years Pancreatic Carcinome /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-t Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical the ass attending p IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No O 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate of Vital 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA A hours after death. uneral Director: After this bly filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Dr. Bel Air, Md. MAN, MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Discourie de		1. Decedent's Name (First, Middle, Last)	BRUCE D. PAI	MER AKA TI	MOTHY J. H.	ANSON Date of D	eath Day	V	e of Death
Physici /Medic			athan He	tuse n		08	29	04 3	Pin
Examin		4a. Facility Name (If not institution, give s	·			n, or Locetion of Dea		of Death	
			2 of Correc			SUP		re Arui	
Funeral Director		210-00-2421	7. Age (In yrs	. last birthday) If Uni Month	der 1 Year If Under 2 ns Days Hours	Min. B. Date of B. (Month, D. Dec 20	nth ay, Year) 1969	9. Birthplace (Sta Country) Maryland	ate or Foreign
yland		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Location	0.000			10d. Insid	le City Limits
the Mai 28e-f s	Funeral Director	MD Anne Arun	idel	Jessup	Zip Code		40- Oiti		Yes 2√∑No
With With	百	House of Correctio	n Road	101.	20794		10g. Citizen of	-	
death	lera			J,S. 13. Was De		in? (Specify Yes or N	o- 14. Rac	USA ce - American Indiar	n,
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. Other 1s marked other then "natural; or items 23e or 28e-f show other traumatic event, the Modical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		cedent of Hispanic Original pecify Cuban, Mexican, Security:	Puerto Rican, etc.)	Bla Specif	ck, White, etc. y: white	
2 hou	ted	15. Decedent's Educ		16a. Decedent's U	sual Occupation	unk	16b. Kind of B	usiness/Industry	unk
should be filed within 7 nd Mental Hygiene. marked other then "n nmatic event, the Med	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give kind of life. DO NOT	sual Occupation work done during most (Tuse retired)	of working			
be filec tal Hyg d other event,	Se C	17. Father's Name (First, Middle, Last)		1	unk 18. Mother	's Name (First, Middle	, Maiden Surnan	ne)	
Mental Merked o	To E				Bet	ty Irene F	almer		
2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type	•	19b. Mailing Addre	ess (Street and Number	or Rural Route Numb	per, City or Town,	State, Zip Code)	
Health Health em 27 i		Md House of Correc			f Correctio	n Road Je	ssup, MD	20794	
Page ent o		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☒ Other (Specify)	emoval from State	Place of Disposition (A cemetery, crematory of	Name of or other place)	Date	20c. Location	- City or Town, State	ə
permit. Departm importar any injurence.		21. Signature of Funeral Service Licenses	ade, Directo		and Address of Facility Anatomy Bo more, MD 2	erd 655 W	. Baltim	ore Stree	et
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the dea				arrest,	Approxi	mate Between
hysician		shock, or heart failure. List only on	e cause on each line.					Interval Onset a	Between nd Death
/Medical		Immediate Cause (Final	Dage	oslue N	Versalas	Cal Di	Sens-	0	
Examiner		disease or condition resulting in death) a	Progre	or as a consequence of	of):	11			
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te be executed ysician and he bunal-transit	Examiner	Sequentially list conditions.	Due to	or as a consequence o	of):			1	
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th cert rendin	an/	d d						1	-
ne death the atte	sici	Part II. Other significent conditions conf	tributing to death but not re	sulting in the underlying	g cause given in Part I.	23b. Did	tobacco use co	ntribute to the cau	se of death?
5 9 0 1	by Physician/M	Suspec	ted CNS	TB	Problems W. S.	1	Yee 2□ No	3 ☐ Probably	I ⊡∕Unknowr
been sign should be	Completed b	HSV				24a. Was	an autopsy ormed?	24b. Were autop available pr	sy findings ior to
as be	ple							available pr completion of death?	or ceuse
ate h	် ပ					10	Yes 2 No	1 ☐ Yes	2 19 No
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r this certiferal directo	၉	1 ☑ Yes 2 ☐ No		ER/Outpatient 3□	DOA Other: 4□ Nurs	sing Home 5 🗆 Res	idence 6 🗷 Oth	er (Specify) 🎤	ison
ding Pl	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occur		
death.	cati	2 ☐ Accident investigation	NIA	М	1 ☐ Yes 2 ☐ N	0			
s after d	edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact	ory, office	28f. Location (City or To	Street and Numb wn, State)	oer or Rural Route N	vumber,
5 2 1	dical	29a. Certifier 1 Certifying Phyei (Check only one)	iclan: To the best of my knower: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and on, in my opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as steted. and due to the caus	se(s)
24 ho E Fune letely f	7.			2	29c. License number		29d. Date signe	d (Month, Day, Yea	r)
Fo the Host within 24 ho Fo the Fund completely f	M	29b. Signature and title of certifier							
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	wer MD	€	0005048	0	091	01 04	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1 1 2 1 7 2 0
	Dhusia		Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dey Year 3. Time of Death
	Physic /Medi		DONALO Erwin Pumphrey of, atober 2 2004 17:00
7	Exami	ner	46 Fecility Name (If not institution, give street end number) 46. City, Town, or Location of Deeth 46. County of Deeth 47. County of Deeth 48. City, Town, or Location of Deeth 49. City, Town, or Location of Deeth 40. County of Deeth 40. City, Town, or Location of Deeth 40. County of Deeth 41. City, Town, or Location of Deeth 42. County of Deeth 43. City, Town, or Location of Deeth 44. County of Deeth 45. City, Town, or Location of Deeth 46. City, Town, or Location of Deeth 47. County of Deeth 48. City, Town, or Location of Deeth 49. City, Town, or Location of Deeth 40. City, Town, or Location of Deeth 41. City, Town, or Location of Deeth 42. County or Location of Deeth 43. City, Town, or Location of Deeth 44. City, Town, or Location of Deeth 45. City, Town, or Location of Deeth 46. City, Town, or Location of Deeth 47. City, Town, or Location of Deeth 48. City, Town, or Location of Deeth 49. City, Town, or Location of Deeth 40. City, Town, o
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		216-18-6306 1 NM 2 F 81 Yrs. Months Days Hours Min. (Month, Dey, Year) 10/9/1922 MD
	ahow		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Man a-fat	ctor	MD Anne Arundel Glen Burnie 1□ Yes 2√√2 No
	th with the Maryla 23s or 28s-f shows ust be notthed at	Pre-	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
	ath w	Funeral Director	501 Pumphrey Lane 21061 U.S.A.
10	fter dea	Ē	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Married 12. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
036	ours af	þ	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify: Specify: White
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. I other than "naturat", or itema 23a or 28e-f ahow avent, the Medical Examiner must be neothed at	Be Completed by	15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working 16b. Kind of Business/Industry
12	d withir piene. r then	dwo	Elementary/Secondery (0-12) College (1-4or 5+) Maintenance Supervisor University of MD
b	filed with I Hygiene. other ther	C	17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
/lar	should be fand Mental Part Merked of	5 B	Percy Columbus Pumphrey Lula May Waters
Man			19a. Informent's Name/Relationship (Type, Print) Sister Mrs. Helen Pumphrey/ in law 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 511 Pumphrey Lane, Glen Burnie, MD 21061
e e	s 1 and 2 of Health Item 27 of her tra	-	20a Method of Disposition 20b Place of Disposition (Neme of Date 20c Location - City or Town State
Baltimore,	S 2 = 7		1 Degation 3 Removal from State 4 Degation 5 Other (Specify) 1 Degation 5 Other (Specify) 1 Degation 5 Other (Specify)
al‡i	permit. Pag Department Important: I any Injury c		21. Signeture of Funeral Service Loensee 22. Name and Address of Facility Singleton Funeral Home P.A.
m	Ped of the ped of the		Moral 1 (a) MO13641 Second Avenue S.W., Glen Burnie, MD 21061
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth) e. END-Stage dementia
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P.0	at tha d by th etach	Phy	iron déficiency anemiz due to 10 you 20 No 30 Probably 4 Munknown
S,	signad	b	
Records,		Completed by Physician/M	Tower GI bleeds 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
Re	The law ata has b page 2 sl	E I	of deeth?
of VItai	lan: T		25. Was cese referred to medical examiner? 26. Piece of Death (Check only one)
7	Physician: this cartific ral director,	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
n c	After t	ion:	27. Menner of Deeth 1 Naturel 5 Pending (Month, Dey Year) Naturel 5 Pending investigation 28b. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Yes 2 No
Division	Attending ar death. actor: After by the fune	flcat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rure) Route Number.
Š	s aftar Il Dira	le l	4 ☐ Homicide building, etc. (Specify) City or Town, State)
	To the Hospital or Attanding Physician: The iaw within 24 buouts aftar death. Othe Funeral Director: After this cartificata has completaly filled in by the funeral director, page 2	edical Certification:	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)
	ithin 2 of the 1		one) end menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	F 3 F 8		MO DO061785 10/6/04
	10	-	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
	Ψ		ETOSHA Dixon MD-6000 Hammonds Lane #LZ Brooklyn Park Md 2123
	Sta Registr	re.	31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature
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			ORIGINAL

da	Schulze		For State Registrar	State of Marylan		artment of H			ene	3:730
			Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physicia		Wanda Schulz	e Parker				Month	Day Year	10 00 PM
>	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	September	r 27, 2004 4c. County of Deat	
1	Examin	51	North Arundel Hos			Glen Bu			Baltimor	ce
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs.		If Under 1 Year Months Days		(Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign
	Director		220-02-06/0	34	Yrs.			Jan. 18		ryland
	pur *	}	Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
	sho	٦ ا								1 1 1 Yes 2 No
	the Marylar 28a-f show	Director	Maryland Anne A	rundel Gle	en Bur			140	022	
	with t	ă				10f. Zip Code		100	g. Citizen of What Co	,
	death with the Maryland ms 23a or 28a-f show	Funeral	611 Old Stage		0 1.0	210			US	
	er de	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.1	Was Decedent of F f Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify:	White
8	hour tural	edt	15. Decedent's Ed		16a Decer	dent's Usual Occur	nation	16	Sb. Kind of Business/	
21215-0036	in 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking	b. King of basillosa	madatiy
12	with ene.	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		Food	Service		Educati	on
9	Hyg Hyg other		17. Father's Name (First, Middle, Last)			rood_,		me (First, Middle, Ma		OII
an	d be ental	To Be	William Sch	11170			Dori	s Kramer		
Maryland	shoul mari	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street		ural Route Number, (Dity or Town, State, 2	Zip Code)
Ma	ith ar ith ar 27 is trau		Terry Parker (H					Glen Bu		
<u>ق</u>	Hea Hea tern othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date 20	c. Location - City or	Town, State
20	ages ant of it: if i		1 ☐ Burial 2 ☐ ☐ Gremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	-	natory`or other pla remator		/5/04 B	altimore	, Md.
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. Its Medical Examitment unit by notified at once.		21. Signature of Funeral Service Licen			. Name and Addre	4			
Ba	permi Depa impo any ir	. 1	Man 4 As	~ MAN485				ns Mortu nnapolis	ary, P.A	401
			23a. Part1. Enter the disease, or com	olications that caused the death	n. Do not ent	B21 Wester the mode of dying	t St. A ng, such as cardia	nnapolls ic or respiratory arres	, Md. 21	Approximate
	2.5		shock, or heart failure. List only				•			Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a MULTIPLE		RIES				
в	Examiner			Due to (or as a consequ	uence or);					
	1000	er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequence)	uence of):					
	nsit	m in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury							
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):					
8760,	certificate be executed iding physician and ise as the burial-transit	dical		d						
68	ificati g phy as the	edlo								
Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	ivery
ă	death e atter ed for u	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnanc Other (specify) _	у		Month	Day Year
P.O.	the y th	nys	9 ⊠Unknown	9□Unknown						
	requires that the de een signed by the a nould be detached f	by PI	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	auire n sig nd blu	D D						1 ☐ Yes	2 ,⊠ No 3 □ Pr	obabiy 4 🗆 Unknown
of Vital Records,	> 0 to	Completed						24a. Was an	24b. Were au	itopsy findings available
Re	0 4 0	mc						autopsy performe	prior to death?	completion of cause of
tal	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				26 Place of Do	tXYes 2[No 125 Yes	2 No
Ξ	ding Physician: h. After this certific funeral director,	00	examiner? 1 Xyes 2 No	Hospital: 1 ☐ Inpatient 2 🔯	ER/Outpatier	t 3FT DOA Ott	nor	Home 5 Residence	no 6 Other (See	2(6)
of	Phy r this eral d	To To	27. Manner of Death	28a, Date of Injury	28b. Time of			28d. Describe how		suy)
on	ding th. Afte	tlor	1 □ Natural 5 □ Pending 2 ★Accident investigation	9/27/04	9:00		rk?]Yes 2, ⊠ No			INVOLVED
Division	dea dea ctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, str			28f. Location (Street	et and Number or Ru	ıral Route Number,
O	after Dira	Certification:	4 Homicide	building, etc. (Specify	v)			City or Town,	E AIDDENS,	LOOK R, BURNE
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor; After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to the cau	se(s) and manner as	stated,
	thin (Med	29b. Signature and title of certifier	A HIGHIGH STATES.	·-	29c. Licens	se number	29d	I. Date signed (Month	h, Day, Year)
	Liv Lo		011012			OCM			eptember 2	
7	Λ.	1	900	and later and the second	00-1 7	D-i-th				
	3		30. Name and address of person who	RUB 10 , HD	1 ∠3a) (Type,	11	1 Penn S	treet, Bal	timore, Ma	aryland 2120
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 7 2004	32. Registrar's Signa	ture	Sports	,			

			1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			ınd Me		giene Reg. No.	004	3 73
	Physici /Medio		Decedent's Name (First, Middle, Last) HY	MAN		PER ⁻	ΓMA N			2. Date of De Month	Day	Year O4	3. Time of Death
)	Examir		4a. Facility Name (If not institution, give s	HOSPITAL		4b. City, T	E	BALTI	MORE		4c. Co	unty of Death	N/A
Ì.	Funeral Director		5. Social Security Number 217-40-0530 Usual Residence of Decedent	7. Age (In yrs	9 Yrs.	If Under 1 Months	Days	Hours	Min.	B. Date of Birt Month, Da FEB. 28	1915	9. Birth Cou	place (State or Foreign intry) POLAND
	Maryland a-f show	tor	10a. State 10b. County N/A		ity, Town or Lo	ocation	E	BALTI	MORE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Director	10e. Street and Number	040		10f. Zip (1015			10g. Citizen	of What Cou	•
336	within 72 hours after death with the Maryland ilone. rthan "natural", or Itams 23a or 28a-f show the Medical Examination multiple in collified at	by Funeral	4004 FALLSTAFF RO	UAU 12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deceder If Yes, specification 1 Yes 2	nt of His y Cuban	21215 panic Orig , Mexican, Specify:		ify Yes or No- ican, etc.)		Race - Ameri Black, White, ecify:	
21215-0036	within liene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use	done du	ion rring most	of working	g	16b. Kind	of Business/Ir	ndustry
Maryland ;	be filed Ital Hyg Id otha evant,	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM		PERTM	AN	1	SARA		(First, Middle,	Maiden Sui		RBIASZ
	nd 2 s lith ar 27 ls r trau		19a. Informant's Name/Relationship (Ty) FRIEDA PERTMAN /			-				Route Numbe			*
Baltimore,	Z = = Z		20a. Method of Disposition 1 📈 Burial 2 □ Cremation 3 □ R 4 □ Donation 🗲 □ Other (Specify)	emoyal from State	Place of Dispo cemetery, crer TIMORE	natory or oth	er place)		Da 0/06/			ion - City or T	own, State
Balti	permit. Pa Departmen Important: any njury once.		21. Signatur uneral service Loos	man	22	2. Na <i>m</i> e and	Address	of Facility	SOL	LEVINS	ON &	BROS.,	
	Physician /Medical Examiner		23a, Patr1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	carolat quence of):	er the mode	of dying,	such as c	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed ohysician and the burial-transit	dical Examiner	Soque Hally list sorrollors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	quence of):	u - 0 = 2	A. i.sc						TO Veys
O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pre					23d.	Date of delive Month	ery Day Year
rds, P	es pe	by	Part II. Dther significant conditions con	atributing to death but not re	sulting in the ur	nderlying car	ise given	in Part I.		23e. Did to	,		he cause of death?
al Records,	The ate h page	Completed								24a. Was a autop perfor	sy	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
ion of Vital	ding Phys n. After this funeral dir	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other: c. Injury a Work?	4 □ Nur:	sing Home	Check onlor 5 ☐ Resid d. Describe h	ence 6 🗆		jy)
Division	al or Attendates after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory,	office		28	f. Location (S City or Tow	treet and Nu n, State)	umber or Rura	al Route Number,
	To the Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at vestigation, in	the time, n my opir	, date and nion, death	place, an	d due to the c I at the time, d	ause(s) and ate and plac	l manner as s ce, and due to	tated. o the cause(s)
)	To the I within 2 To the I Complet	Me	29b. Signature and title of certifier	~ D		A	icense r	number 3 8 9 4	6-E			gned (Month,	Day, Year)
	1		30. Name and address of person who co GAUTAM GULATI 26 I 31. Date filed (Month, Day, Year)	EAST UNIVERSITY	PARKWAY.	BALTIMO	ZE, MÍ	2121	8				
•	Sta Registr		OCT 0 7 2004	32. Registrar's Sign	Locale	<i>J</i> .							

			1 - For State Registrar	State of Mary		artment of I rtificate of			ene . Ng. () () 4	31732
п	Dhunia		1. Decedent's Name (First, Middle, Last))				Date of Death Month	Day Yea	3. Time of Death
1	Physici /Medi		Joseph C. Quir	nn				Septembe	r 25, 20	004 5:45 PM M
7	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of D	eath
			1010 St. Charl	Les Avenue		Balt	imore			
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. I	Birthplace (State or Foreign Country)
R	Director		198–18–8768	M 2□F 8	O Yrs.	I violities Days		Oct 10,		ennsylvania
	p ,		Usual Residence of Decedent	140	Oit T					
	aryta ehov	_	10a. State 10b. County MD	10	c. City, Town or L					10d. Inside City Limits
	Ba-f	ct	TID .		Dalt	imore				ty∏Yes 2□No
	or 2	Funeral Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What	Country?
	23a	a	1010 St. Charles	Avenue		21	229		USA	
	ens ens	ne	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	merican Indian,
9	or It	Y FL	1 ☐ Never Married 2 ▼ Married	1 ∑Yes 2 □ No If Yes, Give 1		1 ☐ Yes 2 ☑ No	Specify:	, , , , , ,	Specify:	
5-0036	Junel.	d by	3 Widowed 4 Divorced	Year or Dates: 2	43-45				Specify.	white
5	within 72 hours after death with the Maryland ane. than "natural", or liems 23e or 28e-1 show is Medical Exercited for routified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	during most of works	ing 16	b. Kind of Busine	ss/Industry
2121	within iene. than	ďω	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire				
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	<u> </u>	at	lministra		(Final Adiable Ad-		racts
anc.	ould be fi Mental It arked ot atic ever	Be	Joseph Francis Q)uinn				o <i>(First, Middl</i> e, Ma ret Amand	r	
7	should nd Men r marke umatic	ပ္								
Maryland	C1 cg 72 60		19a. Informant's Name/Relationship (Type	pe, Print)			and Number or Rura			, Zip Code)
	1 and Health em 27 ther tr		John Quinn/son	12	17 0	sborne Av	enue Balt			
o o	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	1	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pla		Date 20	c. Location - City	or Town, State
Ē	Pag men ant: ury	1 3	* 4 Donation 5 □ Other (Specify)	71						
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Euneral Service License Ronald S. W	ade, Direct	tor S	2. Name and Addre	omy Board	655 W. B	altimore	Street
ш_	205 2 3	9	1 Many	/// WW	B	altimore.	MD 2120	1		Defect
			23a. Pan1. Enter the disease, or compli shook, or heart failure. List only on	ications that caused the ne cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	En	nahus	ema				Onset and Death
1	/Medical		resulting in death)	Due to (or as a co		CVVIA				- gears
	Examiner		Sequentially list conditions,							
72	D #	Examiner	il any, leading to introduce cause. Enter Underlying Cause (Disease or injury	Due to (or as a so	isoquento d):					
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	аш	that initiated events).						
0,	e exe		resulting in death) Last	Due to (or as a co	nsequence of):					
3760	ate b hysic he bi	cal		J						
99	eath certifica attending ph for use as th	Med	IF FEMALE:			-				
Вох	th cer tendin r use	an/I	23b. Was decedent pregnant	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		Ectopic pregnancy	,		23d. Date of d	•
Э.	death ne atte	sicl	in the past 12 months?	4☐Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
P.0	that the de led by the a detached t	Physiclan/Med	9 🗌 Unknown							
Ś	es tha igned I	by	Part II. Other significant conditions con	1			en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
D'C	w require been sig should b		<u>Possible</u>	Lung (iance	<u> </u>		1 🗆 Yes	2 □ No 3	tisbably 4 □Unknown
Record	e taw n has be je 2 sh	Completed		,				24a. Was an	24b. Were	autopsy findings available
m	The t	E						autopsy performed	d? death'	completion of cause of es 2 No
		0	25. Was case referred to medical				26. Place of Death	(Chack only one)	101	2 2 140
>	S S	.O.	examiner? 1 ☐ Yes 2 🛣 No	lospital:	2 ER/Outpatier	nt 3 DOA Oth	00	ne 5 Residenc	e 6 MOther (Sr	necify)
of	ding Phys h. After this funerat dis	E	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	y at 2	28d. Describe how		001177
jo	uttendin death. ctor: Aft y the fun	ate	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	M 1 🗆	Yes 2 □ No			
Division	or Attener deatl after deatl Director: in by the	iţi	3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, str	reet, factory, office	2	28f. Location (Stree	t and Number or	Pural Route Number,
Ö	al or A s after it Dire	Certification:	4 Nottlede	building, etc. (S)	оөспу)		Į,	City or Town, S	rate)	
	spit hours mera y fille		29a. Certifier Certifying Phys	sician: To the best of my	knowledge, deat	h occurred at the tir	ne, date and place, a	and due to the caus	e(s) and manner	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examir one)	ner: On the basis of examination and manner stated.	mination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, date	and place, and di	ue to the cause(s)
	To ti withii To ti comp	M	29b. Signature and title of certifier	0		29c. Licens			Date signed (Moi	
			Y W (B	Ke MI)	DI	6354	SE	PTEMB	ER 30,2004
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	4			
			EW COLE MD	STAGN	ES 900	O CATO	N AVE	BALTIM	ORE M	ER 30,2004 D 21229
	Sta Registr		31. Date filed (Month, Day Year) 004	32 Registrars S	Signatur	Sports				

	_		1- For State of Maryland / Dep	artment of Health and M	lental Hygie	ene 1.00.001 3 733									
	Physic	an	Decedent's Name (First, Middle, Last) Delta and De		2. Date of Death Month	Day Year 3. Time of Death									
	/Medi	cal	Robert Richardson		OCT 4,	, 2004 7:57p [™]									
	Examir	ier	4a. Facility Name (If not institution, give street and number) HCR Manor Care Dulaney	4b. City, Town, or Location of Death Towson		4c. County of Death									
¥.	Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8 Date of Birth	Baltimore									
	Funeral Director		081-32-5616 1X M 2□F 75 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y JAN 16,	(ear) 9. Birthplace (State or Foreign Country) Pennsylvania									
	p.		Usual Residence of Decedent		0111V 10,	1)Z) Tellisylvania									
	arylar show	-	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits									
	Ba-f	ecto	Maryland Baltimore	Parkville		1 □Yes 2 XNo									
	death with the Maryland ms 23s or 28a-f show r natal be notified at	Funeral Director	1303 Dalton Road	10f. Zip Code	10g	Citizen of What Country?									
	eath w	eral		Was Decedent of Hispania Origin? (Spe	oify Van ar Na	USA 14. Race - American Indian.									
(0		Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.									
036	hours after death with the Marylan tural', or Itams 23s or 28a-f show at Evanirer mast be notified at		3 ☐ Widowed 4 🏋 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black									
21215-0036	of filed within 72 hours thygiene. othar than "natural", vant, Ire Medical Exa	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	na 16	b. Kind of Business/Industry									
121	within ene. than "	ldm.	College (1-40r 5+)	kind of work done during most of working DO NOT use retired)	V	Welfare									
	filed v Hygie thar t	ပ္ပ	9 Lati	orer	(First, Middle, Ma	idan Sumama)									
Maryland	iges 1 and 2 should be filed within 72 ho to f Health and Mental Hygiene. If item 27 Is marked othar than "natun or other traumatic evant, Tre Medical	To Be	William Richardson	Margaret		iden Sumame)									
ary	12 should be and Mental ramarked craumatic ev	F		ng Address (Street and Number or Rura		City or Town, State, Zin Code)									
	alth a alth a 27 lg				kville, M										
J.e.	of He		20a. Method of Disposition 20b. Place of Disp			c. Location - City or Town, State									
Ë	Page ment ant: H		TE Buildi E A Cromation o Entomotal nom State	matory, Inc. 10/5/	'04	Baltimore, MD									
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra once.		21. Signature of Tuneral Service Licensee Edward A. Gregorchik	Name and Address of Facility Cremation Society (299 Frederick Road	of MD, In	c.									
	5.		23a, Part1. Enter the disease, or complications that caused the death. Do not en												
	Physician		Interview of Cause (Final Immediate Cause (Fi												
	/Medical		resulting in death) Due to (or as a consequence of):												
	Examiner		Sequentially list conditions, b												
	led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	xecul and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
8760,	ate be executed hysician and the burial-transit	cal													
9	tificate ig phys as the	ledi	<u> </u>												
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery									
	e dea the att	sici	1 Yes 2 No	Other (specify)		Month Day Year									
P.0	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u		00 01111										
S,	signe d be d	by	DIABITES WELLITVS	noerlying cause given in Part I.		co use contribute to the cause of death?									
ör	w requir been si should	etec	15/1/10/1/63 004/66/1/03		-	2 No 3 Probably 4 Unknown									
Rec	sician: The law certificate has t irector, page 2 s	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?									
a	n: Ti ficate or, pa	e Co	25. Was case referred to medical		1 Yes 2 €	No 1 ☐ Yes 2 ☐ No									
5	Physician: this certificatal director, a	To Be	examiner? 1 Yes 2 No	26. Place of Death Other: 4 Nursing Hon		e 6 ⊡Other (<i>Specify</i>)									
1 0	g Phys er this eral di	ä	27. Manner of Death 28a. Date of Injury 28b. Time of		8d. Describe how i										
jor	Attanding Indeath. actor: After by the funer	atlo	2 Accident investigation	M 1 Yes 2 No											
ivision of Vital Records,	or Atta after de Diracto in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number,									
0	urs af														
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)									
	To t To t	Σ	29b. Signature and title of certifier WZ	29c. License number		Date signed (Month, Day, Year)									
	2		30. Name and address of person who completed cause of death (Item 23a) (Type,		U	CI J LUGY									
_	0				wow L	MD 21204									
594	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature												
2	Registr		OCT 0 7 2004 Senera	Looks											
UH	MH 17 Rev 1/20	JU1	/	The second											

ORIGINAL

		1 - For State Registrar 1. Decedent's Name (First, Middle		of Maryla	Cei	tificate of		d Mental Hy	Reg. No.	manufacture of the second of t	3. Time of Deat	
Physicia /Medic	al		lian	M (mber)	Ricc	lardi	or Location of D	OCHOBER	Day 4	Year 2004 ty of Death	12:45f	
Examin	er	Riverwood Village 5. Social Security Number			s. last birthday)	Silver S	pring		Monte	pomery	place (State or For	
Funeral Director		110-03-1349 Usual Residence of Decedent	1 □ M 2 XX F	91	Yrs.	Months Days		Ain. 8. Date of Birt (Month, Da May 13,	1913	Brox	place (State or For htry) Klyn, NY	
a-f show	tor	10a. State 10b. County MD Mor	ntgamery	10c. C	City, Town or Lo	cation ver Spring	ſ		10d. Inside City 1 ☐ Yes			
23a or 28	al Director	10e. Street and Number 3112 Gracefield	Road Apt. 1	PV 403		10f. Zip Code	20904		10g. Citizen of	What Cou USA	ntry?	
	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Dec Armed F ied 1 Tyes If Yes, G Year or I			Was Decedent of f Yes, specify Cul I ☐ Yes 2☐ No		(Specify Yes or No- uerto Rican, etc.) Unk.	- 14. Ra Bl: Speci	ice - Americack, White,		
an "netur	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	st grade completed) (1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. Kind of I	Business/In	dustry	
	To Be Cor	12 17. Father's Name (First, Middle, Cerard Dirier	•	<u> </u>		Iega1		Name (First, Middle,	Number, City or Town, State, Zip Code) aryland 20705 20c. Location - City or Town, State Brocklyn, NY'			
27 is marked r treumetic ev	ř.	19a. Informant's Name/Relations Cerard Ricciardi			19b. Mailin 702	g Address (Stree 5 Storch I	t and Number or ane Seabr	Rural Route Numbe	r, City or Town	n, State, Zip	Code)	
If item or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)		State	Place of Disposementery, crem	natory or other pla	october	Date 7, 2004		-		
Importent: If any injury or once.		21. Signature of Funeral Service	Licensee Victor	P. Doda	/Cn	aries la S	tevens Hi	neral Home,	Inc.	ชา		
ysicia ie bur	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dive to	(or as a consection of the con	iration	in ph cane to t	ed cumo er have	nia_			4 day 2 day	
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Fet nant at time of nown	al death 3 🗌	Ectopic pregnanc Other (specify)	y			ate of delive	ery Day Year	
igne be d	by	Part II. Other significant condition	ns contributing to c	leath but not re	sulting in the un	derlying cause gi	ven in Part I.		_		ne cause of death	
ate has been si page 2 should	Completed							24a. Was a autop: perfor 1 Yes	med?	prior to cor death?	psy findings avai npletion of cause	
recl	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatient	2C DOA Ott		Death (Check only or			,	
<u> </u>	\vdash	27. Manner of Death 1 Attural 5 Pending 2 Accident investig	28a. Date (Mor	of Injury ofth, Day Year)	28b. Time of Injury	28c. Inju	4 Marinusing	28d. Describe h			//	
filled in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place	e of Injury - At h ing, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (S. City or Town	treet and Numi n, State)	ber or Rura	l Route Number,	
	dical	one) 2 Medical I	xaminer: On the band mar	asis of examination	ation and/or inv	occurred at the ti estigation, in my	me, date and pla opinion, death oc	ace, and due to the courred at the time, d	ause(s) and m late and place,	anner as st and due to	ated. the cause(s)	
To th comp	W	29b. Signature and title of certified	Puthum	ang,	MD	29c. Licen:	5952		9d. Date signe		Day, Year)	
10		30. Name and address of person		se of death (Ite	m 23a) (Type, F	Print)		LVERSPR			20904	
Stat	te	31. Date filed (Month, Day, Year) OCT 0 7 200	# 32. F	Registrar's Sign	ature	parker	~,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		7		,,	

amend 2 per Dr.

8 per A.B. g839 1/20/05 KBH
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

					State of Ma	aryland /	•	rtment of F tificate of		мептат ну	giene Reg. No.		21725
			1. Decedent's Name (F	First, Middle, Las	t)					2. Date of De	eth 22		3. Time of Death
	Physici		CHET	ONIC	HARLE	SRA	(FE	RS		Month	1 22		1530
1	/Medic Examir		4a Fecility Neme (If no	ot institution, give		5 10	<u></u>		4b. City, Town, o	r Location of Deat			1000
1	Lxamii		University	of m	ARYLAN	0		1	SAI Time	DRE CIT	Not	A 001	ICABLE
	Funeral		5. Social Security Number	ber 6. Se	7. Age	(In yrs. lest b	irthdey)	If Under 1 Year	If Under 24 Hr	's. 8. Date of Bir	th	9. Birthpla	ace (State or Foreign
	Director		none	1]	M 2□F		Yrs.	Months Deys	Hours Mir	n. (<i>Month, De</i> Sept – 2	th ey, Year) 3-222004	Counti	7) 71and
	-	'	Usuel Residence of De	cedent						12-11-			
	how how		10a. State 10	0b. County		10c. City, Tov						10	d. Inside City Limits
	Ma Ma	cto	MD			Ba	ltimo	ore					1X Yes 2 □ No
	# 22 #	Funeral Director	10e. Street end Numbe)r				10f. Zip Code			10g. Citizen of	Whet Countr	ry?
	th wi	ai	439 Yale	Avenue				2	21229		Ţ	JSA	
	9 4	ner	11. Marital Status		12. Was Decedent 6 Armed Forces?	er in U,S.	13. W			Specify Yes or No orto Rican, etc.)		ce - America	
020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haatih and Mental Hygiene. Department of Haatih and Mental Hygiene. Insportment of Haatih and Mental Hygiene and Insportment if Items 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Š	1 Never Married 3 ☐ Widowed 4 ☐		1 Yes 27 N If Yes, Give Year or Detes:	lo		☐ Yes 2X No	Specify:	nto riioari, oto.,		blac	
ŏ	2 ho	Be Completed	15.	. Decedent's Edi	eation	168	. Decede	ent's Usuel Occup	pation		16b. Kind of B	usiness/Indu	ustry
2	hin 7	pie	(Specify of Elementery/Seconda	only highest grad	e completed) College (1-4or 5	4)	(Give k	ind of work done O NOT use retire	during most of wo d)	orking			
7	d the	E	none		ione	'	none				none		
פ	of the H	ě	17. Fether's Neme (Firs	st, Middle, Last)					18. Mother's Na	ame (First, Middle		ne)	
<u>a</u>	Aents Aents rked tic e	10	CI	lifton R	logers					Josephin	e Davis		
a	ohs and h		19a. Informant's Name	/Relationship (7	ype, Print)	19	b. Mailing	Address (Street	and Number or F	Rurel Route Numb	er, City or Town,	Stete, Zip C	Code)
Σ	alth alth	- 1	UMMS				22	S. Green	Street	Baltimo	re, MD	21201	
Baltimore, Maryland 21215-0020	of Ha		20a. Method of Disposit		Removal from State			ition (Name of atory or other plac	се)	Date	20c. Location -	City or Tow	m, State
Ē	ment ant: I		4 Donation 5 D	Other (Specify,	in state	7							
32	permit Depart Import any in		21. Signature of Eunera ROD	al Tryice Licens	Wade, Dire	ctor	St.	Name and Addre	ss of Facility OMV Boar	d 655 W.	Baltim	ore St	rreet
	70 E 8 9		Xmu	WII	1//1/10	111 _		ttimore,				010 00	11000
			23a. Pert1. Enter the d shock, or heart fa	liseese, or comp	lications that caused ne cause on each lin	the deeth. Do	not enter	the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,	1	Approximate Interval Between
3	Physician												Onset and Death
man of the same	/Medical Examiner		Immediate Ceuse (Fina disease or condition	al	e Extre	me (Drev	mturis	L.1			:	
	Lxammer	_	resulting in death)			Oue to (or es e	-		7				
	β ÷	ine			h							i	
	ificate be executed g physicien end es tha buriel-trensit	edicai Examiner	Sequentially list conditi	ions,		Due to (or es a	consequ	ence of):					
68760,	cien cien burie	E E	Sequentially list conditi if eny, leading to immed cause. Enter Underlyin Ceuse (Diseese or injust that initieted events	ng ry	c								
84	phys:	G	that initieted events resulting in death) Last			ue to (or es e	conseque	ence of):					
×					d								
8	ath o atten for u	ig											
P.O. Box	the de	ysic	Part II. Other significan	it conditions co	ntributing to deeth bu	t not resulting i	n the und	lerlying cause giv	en in Pert I.	23b. Did	tobacco use co	ntribute to t	the cause of death?
α.	The law requiras thet tha death certific site hes been signed by the attending p pege 2 should be detached for use es	by Physician/M								1 🗆	Yes 2 No	3 Proba	ably 4 ☐ Unknown
Vital Records,	sign sign dbe	Q P								24a Was	an autopsy	24b Wer	e autopsy findings
Š	peen peen shou	ete								perfo	rmed?	avail	lable prior to pletion of cause
ĕ		Completed								150.00	DAMES OF STREET	of de	eath?
	r, peg	රි								453	fes 25 No	10	Yes 2□ No
=	Physician: The lar r this certificate hes arel director, pege 2		25. Was case referred t examiner?	⊢	lospital:			2□ DOA Oth	or.	eath (Check only o			
ō	Physical States	5.	1 ☐ Yes 2 ☑ No 27. Menner of Deeth		1 m Inpatier		utpatient Time of	3LI DOA	4 🗆 Nursing i	Home 5 Resident	dence 6 ⊟Otho now injury occurr		
Division of	Attending ar deeth. ector: After by tha fune	盲	1 Naturel 5	Pending investigation	28a. Date of Injury (Month, Dey	Year)	Injury	28c. Injur Wor M 1	k? Yes 2 ⊡No		iow anjury occurr	00	
2	deet deet ctor: y tha	lica	2 ☐ Accident 3 ☐ Suicide 6	Could not be determined	28e. Place of Inju	rv - At home, fa	arm. stree			28f. Location (S	Street end Numb	er or Rural I	Route Number.
2	or Attending P setter deeth. I Director: After t d in by tha funere	ert	4 Homicide	determined	building, etc.	(Specify)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov	vn, Stete)		
	To the Hospital or I within 24 hours efter To the Funeral Director Complately filled in the Internal Processing of the Internal Processing I with I w	Medicai Certification:			sician: To the best of ner: On the basis of								
j	thin 2: the F mplat	Z Ked	one) 29b. Signature end title		and manner stat	ed.		29c. Licens			29d. Date signed		γ
	Z × Z S	-	D. Orginature end title	1/10	h	_		Loo. Liberts			_		
			Bett	" Juli	w m	D		DV41	764353	15793	Septem	ber 2	3 2004
			30. Name end eddress	1		^			1			- 19-	210 11
			31. Date filed (Month, D		University 32. Registre		ylan	0 77 2	. Oreene.	st. Balt	imore P	11) 2	1201
	Sta Registr	re		0 7 2004	boren	en fi		A Part of the Part					
			-	1		15-1		1111. 16 1					

DHMH 16 Rev 6/95

amend 2 per Dr. 8 per A.B. g839 1/20/05 KBH

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	Please Type	or Print in	Black Indelible Ink.	Ensure All Copies Are Legib	le.

Social Security Number Social Security Num	9. Birthplace (State or Foreign Country) Mary Land 10d. Inside City Limits 12 Yes 2 No
Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Color	9. Birthplace (State or Foreign Country) Mary Land 10d. Inside City Limits 12 Yes 2 No
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Comparison of Death 4c. Comparison of Death 4c. Comparison of Death 4d. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Comparison of Death 4c. Comparison of Death 4d. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min. Sept 2322 200 Usual Residence of Decedent	9. Birthplace (State or Foreign Country) 104 Mary Land 10d. Inside City Limits 12 Yes 2 No
Funeral Director 5. Social Security Number none 5. Social Security Number none 6. Sex 1 Months Days Hours Min. Sept 232,2 20 Usual Residence of Decedent	9. Birthplace (State or Foreign Country) 104 Mary Land 10d. Inside City Limits 1 √2 Yes 2 □ No
Director Director Director Usual Residence of Decedent Director 1 □ M 2 ☒ F Yrs. Months Days Hours Min. (Month, Day, Year) Yrs. Months Days Hours Min. (Month, Day, Year) Sept 2322 2 €	104 Maryland 10d. Inside City Limits 1√2 Yes 2□No
Usual Residence of Decedent	10d. Inside City Limits 1½ Yes 2 □ No
The property of the property o	1★ Yes 2 No
Baltimore 106. Street and Number 106. Str	21
The property of the property o	of Milest Courts O
439 Yale Avenue 12	of What Country?
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexican, etc.) 1. West Decedent of Hispanic Origin? (Specify Cuban, Mexica	USA
The part of the pa	Race - American Indian, Black, White, etc.
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind (Give kind of work done during most of working life. Do NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16d. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Specify only highest grade completed) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired) 16d. Near of work done during most of working life. Do NOT use retired)	ecity: black
(Specify only highest grade completed) College (1-4or 5+)	of Business/Industry
none none none none none none none none	
Tr. Father's Name (First, Middle, Last) Clifton Rogers Clifton Rogers Josephine Davis Josephine Davis Josephine Davis Josephine Davis Josephine Davis	
JOSEPHTHE DAVIS JOSEPHTHE DAVIS 109 Informant's Name/Relationship (Type Print) 109 Mailing Address (Street and Number or Rural Route Number City or T	
UMMS 22 S. Green Street Baltimore, MD	21201
20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locat	ion - City or Town, State
O SO SE S 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Burial 2 □ Cremation 5 M Other (Specify) in state	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Mother (Specify) in state 21. Si nature Euneral Septence Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Balt Baltimore, MD 21201	imore Street
23a, Part. Enter the disease, or complications that bassed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Extreme Prematurity	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b.	
Trany, leading to immediate	
g e resulting in death) Last Due to (or as a consequence of):	
aate be en anysician the burian the burian dical E	
ilicate be g physicia as the burn as the b	
The part of the past 12 months? If FEMALE: 23c. If yes, outcome of pregnancy 1	. Date of delivery
So the second of	Month Day Year
O ent to be	contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use	
S so so so so so so so so so so so so so	4b. Were autopsy findings available
autopsy performed?	prior to completion of cause of death?
To the company of the	1 Yes 2 No
25. Was case referred to medical axaminer? 1	Other (Specify)
1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 L 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury or Injury 28d. Describe how injury 08d.	ccurred
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286. Date of Injury 18 Natural 2	umber or Rural Route Number,
29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and (Check only (Check only (Check only added)). Implicit the time of the	
one) and manner stated. 29b. Signature and title of centifier 29d. Date s	gned (Month, Day, Year)
12 7/1/1/1005	mber 23, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	,
Beth Jelinek, MD University of Maryland 22 S. Greene St. Baltimore M	D 21201
State 31. Date filed (Month, Day, Year) Registrar OCT 0 7 2004 Separator Aparator	

		1 - For State Registrar	State of Ma	ryland		artmen rtificat			nd M	ı	Reg. No	000	To the second se	31737
Physic /Med Exam	lical	Decedent's Name (First, Middle, Las Sister Theodosia R 4a. Facility Name (If not institution, give	eynolds, 0.5			4b. City,	Town, or	Location of		2. Date of Dea Month	Da BER	-	ear 21214 Death	3. Time of Death 6:仅仅户
Funera Directo	_	215-30-4540			cer est birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	OWSC 24 Hrs. Min.	8. Date of Birt (Month, Day April 26	h y, Year) , 192			inore ace (State or Foreign ry) and
the Maryland 28a-1 show	ector	Usual Residence of Decedent 10a. State 10b. County Md. Baltimore		10c. City,	Town or Lo	cation	Code							d. Inside City Limits 1 ☐ Yes 2 ☑ No
ire, Maryland ZIZIO-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, the Medical Examinar must be notilised at	by Funeral Director	7601 Dsler Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:				21204 dent of His city Cubar	spanic Orig n, Mexican, Specify:	jin? (Spe Puerto I	city Yes or No- Rican, etc.)				ın Indian,
Maryland ZIZI3-UU30 d 2 should be filed within 72 hours af tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)			dent's Usu: kind of wo DO NOT u .stian	rk done di se retired)	uring most		ng (First, Middle,	Cath	ind of Busi	hapel	ŕ
Maryland 12 should be fil 2 should be fil 2 should be fil 7 is marked out	To Be	17. Father's Name (First, Middle, Last) Francis Reynolds 19a. Informant's Name/Relationship (7) Sp. Management St. John	ype, Print)				(Street a	Ji nd Number	ulia r or Rura	Curran Route Numbe		,		Code)
Baltimore, IN permit. Peges 1 and Depertment of Health important: if item 27 any injury or other tr		Sr. Margaret St. John 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		Ce	ace of Dispo metery, crer Holy F	esition (Nar natory or d	ne of other place er Cem	. 10	 □-12-l	ate	Balt	ocation - C	•	vn, State
Depermit. Depermit. import	KING THE STREET	21. Signature of Funeral Service Licen 23a. Part1. Enter the disease, or comp	plic lions that caused	the death.						, Ma. 212		7150	TEV I C	Approximate
SY 60, tate be executed Examine executed bysician and the burial-transit	ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a conseque	ence of):	R AC	CIDE	ENT						Interval Between Onset and Death
i, P.O. BOX 68 i that the death certifical ned by the attending phy edetached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 226 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p						23d. Date Month		y Day Year
The law requires that the tee has been signed by the page 2 should be detached.	5	Part II. Other significant conditions of HYPERTENSION	ontributing to death bu	ut not resul	Iting in the u	nderlying o	ause give	n in Part I.		23e. Did to		h		a cause of death?
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on o	ertification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	1 Panpatient 2 EH/Outpatient 3 DOA 4 Nursing Hor					ne 5 Resid	dence now inju	ry occurred	1		
DIVISIC Hospital or Attence 44 hours after death Funeral Director: tely filled in by the 1	O	4 Homicide determined 29a. Certifier 12 Certifying Ph	building, etc	of my know) viedge, deati	h occurred	at the tim	e, date and	d place, a	City or Tow	vn, State) and manr	ner as sta	Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier 30. Name and address of person who	iner: On the basis of and manner sta	ited.	A	296	c. License		h occurre		29d. Da	d place, an	Month, D	lay, Year)
S Regis	tate strar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ER D	Lon	TO	ISON	MAR	YLAND-		7/4		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Saunders 12.49 PM 2004 6h /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 20 1961 6. Sex 5. Social Security Number Birthplace (State or Foreign Country)
 Md **Funeral** 1 ☐ M 2 🛱 F 218-80-1310 Director Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Md Carrol1 Eldersburg 1 Tyes 2 TiNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2822 Lakeview Avenue 21784 USA permit. Pages 1 and 2 should be filed within 72 hours after death vibrantiment of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or items 23s any injury or other traumatic event, the Natural. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, GiveA Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles O'Donnell Mary Trent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Saunders (spouse) 2822 Lakeview Ave., Eldersburg, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sharon Baptist Cem. 10-09-04 Lisbon, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Buan d P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Atherosclerchic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or httpriding Physicien: The law requires that the death certificate be executed after death.

Director After this certificate has been signed by the attending physician and use as the burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 25 No After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a To the Funaral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 100 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21221 MAHMOOD 201-109 Back River Neck Rd Bultimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SULLIVAN KOSE 2004 OCT 14:10 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** COUNTY GENERAL HOSPITAL HOWARD HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 ☐ M 2 🗙 F Days Months Hours Min. Yrs 220.24.9979 76 Director June 26, 1928 Maryland Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28e-f shov traumatic evant, I're Modical Exercitrar reast by ricitified at 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 5110 Montgomery Road U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at home Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Fredericks Agnes Irene Gover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5110 Montgomery Road Ellicott City, Maryland 21043 Ms. Vickie Delawder Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or once. 14 ☐ Donation 5 ☐ Other (Specify) 10/05/2004 Baltimore, MD **Bayview Crematory** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PELVIC Pnysician CANCER MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) be detached 9☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CARBIAC ARRHYTHMIAS; HYPOTHYRUIDISM After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 1 Tyes the Hospitel or Attanding Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funaral Completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May ins 3 38296 OCT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 95010LD ANNA DOUSED, SWITE ZOZ, ELLICOTT CITY, MD ZIOYZ GIBBONSMD 32. Registrar's Signature Registrar ocker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Amend item 19a p	er fh g836	•					leg. No?	Ola	31710
	Physici	an	Decedent's Name (First, Middle, La	ist)					2. Date of Dee Month	2. Date of Deeth Month Day Year		
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	Funeral Director		217-30-3448	Sex 7. Age 1	(In yrs. last birt		der 1 Year is Days	If Under 24 Hrs Hours Min		1925	9. Birthp Cour MD	place (State or Foreign htry)
	and *		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
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020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than *natural', or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	by	1 Never Merried 2 Married 3XXVIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				an, Mexican, Pue Specify:	rto Rican, etc.)		ck, White, ' [:] Blac	
5-0	72 h	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Us	sual Occup	nation during most of wo	orkina	16b. Kind of B		
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pu	al Hygi I other vent, I	Be (17. Father's Neme (First, Middle, Last	EWELL.				18. Mother's Na	me (First, Middle,	Maiden Surnam	10)	
Maryland	Mental I	2	Clarence S	well				Hazel	Matthe	ws		
lar	and and a		19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Addre	ess (Street	and Number or R	lural Route Numbe	, City or Town,	State, Zip	Code)
	and n 27		EQUATO DESCRIPTION	Nephew				t.,San	Francis	co,Cal	.ifor	nia94117
Ore	ges 1 t of H if iter		20a. Method of Disposition **Dispurial 2 Cremation 3 C	Removal from State	20b. Place of cemeters	Disposition (A y, crem <i>atory o</i>	lame of r other plac	ce)	Dete	20c. Location -	City or To	wn, State
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Baltimore,	Depart Depart Import any in		21. Signatur of Fune I Service Licer	Hervel	N	20-20-		ss of Facility H erty He	owell F ights A	uneral ve.Bal	Hon	MD.21207
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of <	Q 50 Z	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 🗆 ER/Out	patient 3 🗆 [Nursing I	Home 5 ☐ Reside	nce 6 □Oth	er (Specify)
ou o	After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	/ear) 28b. Ti	ime of jury M	28c. Injun Worl 1 □	yat k? Yes 2 □ No	28d. Describe ho	w injury occurr	ed	
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	To the To the Compla	2	29b. Signature and title of certifier	0		2	9c. License	e number	2	9d. Date signed	(Month, L	Day, Year)
			> 50	lun			03	0641		Ochde	4	2004
)	0	30. Name and address of person who have the second	completed wase of deal	th (Item 23a) (1	Type Print)	Kin	4 Neck	Loca L	Balfin	ox h	aylen 2p21
	Sta		31. Dete filed (Month, Day, Year) OCT 0 7 2	32. Registrer's					- 1			-1

DHMH 16 Rev 6/95

Charlotte Selph 04-06385 RPD

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	Physici /Medi		Charlotte J. Selp	h				Octobe	er 3, 2004	1110 A M			
	Examir	ner	4a. Facility Name (If not institution 3006 Huron Stre	et		Baltimo			4c. County of De	eath			
35	Funeral Director		5. Social Security Number 217–46–3727 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days		n. (Month, Da	9. E 10, 1948	irthplace (State or Foreign Country) Maryland			
γ.	the Maryland 28e-f show notified at	or	10a. State 10b. County	N/A	10c. City, Town or Lo	ocation	Baltimore	City	10d, Inside City Limits XX Yes 2 □ No				
	with the had or 28e-i	Director	10e. Street and Number 3006 Huron Street			10f. Zip Code		city	10g. Citizen of What				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, I'm Madical Examiling manning once.	by Funeral	11. Marital Status 1 Never Married 2 Marr 3XXWidowed 4 Divorced	If Yes, Give	₩vo	Was Decedent of lif Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	USA 14. Race - Ar Black, WI Specify:	nerican Indian, nite, etc. White			
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imore	Pages 1 ment of Ho ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 XX emation '4 ☐ Donation 5 ☐ Other (S	pecify)	Bay View C	matory or other pla	October 6	Date 5, 2004	20c. Location - City of Baltimore N				
Balt	permit. Depart Import any inj once.		2 Signature of Funeral Service	Licensee Victor P.		Name and Addrescription 12. Name and Addrescription 15. Name and Nam	Stevens Fi	neral Home	, Inc. e Maryland 2	21220			
8760,	Physician /Medical Examiner physician and physician and the purial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheros Due to (or as	sclerotic Cass a consequence of): s a consequence of): s a consequence of):				1031,	Approximate Interval Between Onset and Death			
P.O. Box (ires that the death certifica signed by the attending ph d be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	Blivery Day Year			
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	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	Hallan	and.	29c. Licens			29d. Date signed (Mon				
			30. Name and address of person	who completed cause of	death (Item 23a) (Type,			Doll+i	October 4				
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)			porks	JIICEL,	DOTUMBL	e, Marylan	u 21201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 2004 October 6, Year **Physician** Dorothy T. Schrader 1100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** 1□ M 2□ F Months Director 217-07-8516 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Harford Abingdon Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 United States 2845 Bynum Overlook Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2 XNo Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years office worker state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should banent of Health and Mental Mary Posko Joseph Watroba 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 shing beatment of Health and Important: If Itam 27 is many injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2345 Bynum Overlook Drive, Abingdon, Md. 21009 Peter Schrader/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 10/11/2004 Baltimore, Md. 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of). **Examiner** 3 DAY 5 Sequentially list conditions, nary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Physician/Medlcal IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTURE PULMONTRY DISTING 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed CONGETTIVE HEART 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D08096 BCTEBER 6, 2004 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

OCT **0 7** 2004

DOROTH

SCHEP DER,

#291580

Andrew Nowakowski, M.D., 125 North Main St., Bel Air, Md. 21014

32. Registrar's Signature

			For State Registrar	State of M	aryland /		rtment of F <i>lificate of</i>		mentai H	/gien Reg. N	2001	- /	21713
			Decedent's Name (First, Middle, L.)	ast)					2. Date of D	eath		- 1	3. Time of Death
	Physicia /Medic		Webster Lee Si	nith, Jr.					Octobe		ay 2004	or	9:25 P M
	Examin		4a. Facility Name (If not institution, g					r Location of Deat	h	4	c. County of De		
			Oak Crest Rena			N	Parks	VILLE	100.45		Baltim		
	Funeral Director		5. Social Security Number 220-14-0699 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last b	Yrs.	Months Days	Hours Min.		av. Year	924 M	Countr	ce (State or Foreign V) Land
	r 28a-f show		10a. State 10b. County		10c. City, To	wn or Loc						100	1. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	cto	Maryland Balti	nore			Parkvi	lle					
Q	with the	Funeral Director	100. Street and Number 8810 Walther BL	ud, Room 30	19 South	'n	10f. Zip Code 21:	234		10g. C	U.S.A.	Countr	y?
25	death ms 2	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. W	/as Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	lo-	14. Race - Ar Black, W		
NeDSter 7	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f show the Medical Experiment met be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced		No		☐ Yes 2∭ No	Specify:	to ritoari, otc.,		Specify: (
5-0	72 hours "natural",	eted	15. Decedent's (Specify only highest of	Education grade completed)	16	a. Decede	ent's Usual Occup	pation during most of wo d)	rking	1	Kind of Busine		•
057EF d 21215-	be filed within 72 ho tal Hygiene. d othar than "natur event, the Medical	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or	5+)		ONOTuso rotiro L'Engine			1	vil Eng mpany	1ne	ering
2 2	filed v Hygie thar 1	CO	17. Father's Name (First, Middle, La	st)			Lighte	18. Mother's Na	me (First, Midda		•		
lan	id be ental kad o	To Be	Webster Lee Sm	ith, Sr.				Mary A	Ubina	Slap	oak		
当と	permit. Pagas 1 and 2 should be filed within Departmant of Haalth and Mental Hygiene. Important: If item 27 is markad other than any injury or other treumatic event, I'm Monee.	۲	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address (Street	and Number or Re	ural Route Num	ber, City	or Town, State	e, Zip C	code)
Z Q Z	and 2 laith a 127 is		Mr. Webster Lee:	Smith, III	son)	3802	Pineda	le Drive,	Baltin	iore,	MD 21	236	
ore t	as 1 a of Ha		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State		of Dispos tery, crem	ition (Name of atory or other pla	се)	Date	20c. l	Location - City	or Tow	n, State
Z E	Pag mant lant: I		*4 □Donation 5 □ Other (Spe	cify)	Dulan			n'l 10/0					- Alf
SNIT	permit. Departi Import any inj		21. Signature of Funeral Service Lic	ensee		22.	Name and Addre	ess of Facility Sc	chimunek	Fur	reral H		ડ
· ,	20 5 8 0		23a. Part 1. Enter the disease, or co	unalizations that cause	d the death. Dr			ur Rd.,			MU 21	236	Approximate
			shock, or heart failure. List or	ly one cause on each I	ine.				o or respiratory	arrost,		1	nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a)	emento		end s	tape				1	nonths
	Examiner			Due to (or as	a consequenc	e or):							
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc	e of):							
	cacuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ö.	ate ba exacuted by sician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequenc	e of):							
8760.	cate ba ex physician the buria	dical		d									
9			IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of	deliven	,
Bo	eath c atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal dea		Ectopic pregnanc Other (specify) _	у			Month		ay Year
Ö	the d by the ached	ysi	1 Yes 2 No 9 Unknown	9☐ Unknown									
Vital Records, P.O. Box	Attending Physician: Tha law requires that the death certificate the control of the control of the attending ecters. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Pt	Part II. Other significant condition	s contributing to death i	out not resulting	în the un	derlying cause gi	ven in Part I.	23e. Dio	tobacco	use contribute	to the	cause of death?
rds	quire en sig vuld b	ed b							1 🗆	Yes 2	21/21No 3□	Probal	oly 4 ∐Unknown
ဝင္ပ	law re as bec 2 sho	Completed		····					24a. Wa	s an opsy	24b. Were	autops to com	y findings available detion of cause of
Ä	Tha ata ha page	Com								formed?	death	?	Dho
K i	cian: ertific actor,	Be	25. Was case referred to medical examiner?	Lia saitale			O#	26. Place of De					
Jo Jo	Physi this c	10	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpati		Outpatient Time of	3 DOA		Home 5 ☐ Re 28d. Describe			pecify)	
	ding l	tlon	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Injury	28c. Inju Wo M 1	rk? Yes 2 □ No	ZOG. DOGCHE	7 110 11 111)	ary occurred		
Division	Attended deatlers ctor:	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Ir	jury - At home,	farm, stre	et, factory, office				and Number or	Rural I	Route Number,
Div	s after	Certification;	4 Homicide	building, e	tc."(Specify)				City or I	own, Sta	te)		
	To the Hospital or Attending Physician: Tha taw within 24 hours after death. To tha Eunerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical O	29a. Certifier Certifying (Check only one)	Physicien: To the best aminer: On the basis and manner s	of examination	lge, death and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to thurred at the time	e cause(e, date ar	s) and manner nd place, and o	as stat	ed. he cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. D	ate signed (Mo	onth, Da	ay, Year)
	. >- 0) (And	100			05	3115		00	Chh 6	th :	2004
	TL.		30. Name and address of person w			-			1				
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	Sta Registi		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		bouls						
	negist	2001	OCT 0 7 2004	Sin	- 19	-	parket						

			State of Maryland / Department of Health and Certificate of Death	0.0.01
			Decedent's Name (First, Middle, Last)	2. Dete of Deeth 3. Time of Death
1	Physicia /Medic	al	JAMES STEVENSON 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, c	Month Day Year 1394M
_/	Examin	er	Genesis Elder Care - Perring Parkway Baltin	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 H Months Days Hours M	Irs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		Usuel Residence of Decedent	Dec. 28, 1922 Maryrana
	how .		10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-fa	Ç	Maryland Baltimore Baltimore	1 ☐ Yes 2 ☑ No
	th with the 23a or 2	Funeral Director	10e. Street end Number 10f. Zip Code 2123	10g. Citizen of What Country? U.S.A.
020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	۵	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 No If Yes, Specify Cuban, Mexican, Put 1 Nover Married 2 No If Yes, Specify Cuban, Mexican, Put 1 Nover Married 2 No If Yes, Specify Cuban, Mexican, Put 1 Nover Married 2 No Specify:	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0020	filed within 72 ho Hygiene. ther then "natur ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during mo	vorking 16b. Kind of Business/Industry Baltimore City
d 2	Hygid offher ent, to		90	lame (First, Middle, Maiden Sumame)
ylan	should be and Mental a marked o	To Be		ssie Kelly
Mai	d 2 sh th and 7 is rr traum		19a. Informant's Name/Relationship (Type, Print) Mr. Jim Stevenson (son) 3701 Oakfalls Way, R	Rural Route Number, City or Town, State, Zip Code) Baltimore. MD 21236
ē,	Heat Heat tem 2		20a Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
E O			1 \(\sum \) \(\text{Surial 2 \subseteq Cremation 3 \subseteq Removal from State } \) 4 \(\subseteq \text{Donation 5 \subseteq Other (Specify)} \) 1 \(\subseteq \text{XBurial 2 \subseteq Cremation 3 \subseteq Removal from State } \) 1 \(\subseteq \text{Loudon Park Cemetery.} \)	10/11/04 Baltimore, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sc	chimunek Funeral Homes Baltimore, MD 21236
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. Drugger De Unit Due to (or as a consequence of):	Interval Between Onset and Death
		Jer	Due to (or as a consequence of):	
	ficate ba axecuted physician and is the bunal-transit	Examiner	Sequentially list conditions, Due to (or as e consequence of):	
90	oa axe cian a cian a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	į
68760,	ficate t physics the t	edicai	triat initiated events Due to (or as e consequence of):	0
_	- CO M		a. Horythma Status Post	Paremake
Box .	Jeath atter d for u	clar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco use contribute to the cause of death?
P.0	The law requiras that the death certi te has been signed by the attending page 2 should be detached for usa a	/ Physician/M	Peripheral variously disease	1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	v requiras been sign should be	ted by	Subclass Steel Sundame	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
Rec	The law rate has by page 2 sh	Completed	Braine	completion of cause of death?
ita	. 60	0	25. Was case referred to medical 26. Place of D	eath (Check only one)
_	S S	T0 B	examiner:	Home 5 ☐ Residence 6 ☐ Other (Specify)
	g age		27. Menner of Death 1 Statural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 4 Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how injury occurred
Division	or Attending after death. Director: Attendin by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant of the plant occurred at the time, date and the time occurred at the time, date and the time occurred at the time.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	a V		Darrant MD D3146	1 dutul
	127	'	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIIZ A-LHASIHMI, 821 N. Entaw St	Inte 308 Bellimore MI
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrer's Signature	21201

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARIA 1615 Angelina JANTANA OU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner pper Chexapesile Hartova Medical Center Bel If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 □ Hours Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itema 23s or 28s-f show ury or other traumatic event, I to Medical Evant and Loud to a constitute to constitute and the modified and the constitute of the medical Evant and the modified and the constitute and the 1 ☐ Yes 2 No Abingdor Md Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 726 21009 rederal USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Dever Married 2 Married 1 ☐ Yes 2 X No Black Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) New born none none 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Santana Mector MARyel ပ Kachel Patrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Upper Chesapeake Medical Ctr 500 Upper Chesapeake Way Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State important: I any injury o once. 4 Donation 5 Other (Specify) neral Service Kena Id 22. Name and Address of Fac State Anatomy Baltimore, MD icensee Wade Board 655 W. Baltimore Street 21201 Enter the disease, or complications that, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician att /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month Day Year 5 Other (specify) 9□ Unknown 04 ΙO 9 Unknown n signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page this certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only оле 9 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar KathleenM

DHMH 17 Rev 1/200

425904

Angelina Maria

Santana,

520 Upper Chesapeake Dr. Sta. 301, Beldir, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07 2004

Gotzmann M.D.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** SAVAGE 10:30 PM HENRY GEORGE OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (ENTER BALTIMORE VA MEDICAL BALTMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 01–10–1921 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 215-16-0325 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Baltimore Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3311 Liberty Heights Avenue Apt B8 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or tler eny injury or other treumatic event, the Medical Evanfrat 1 X Yes 2 □ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintainance Man Home Improvement 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Savage Leona Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Hadee/ Son 2730 Prospect St. Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veteran 10-08-04 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 226. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CEREBOOVASCULAR ACCIDENT 10 402-5 /Medical Due to (or as a consequence of) Examiner CARCINUMA PROSTATE Ye2/3 Sequentially list conditions, in any, leading to ministrate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMENTIA has autopsy perform 1 Yes 2 No 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 🖾 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospitel 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and of certifie 10-4-2004 30. Name a a a re of person who completed cause of death (Item 23a) (Type, Print) ZIBERSTEIN BACTIMORE, MD M.O. 10 GREENE ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 7 2004 Registrar Cools

04-06295 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. JOHN PAUL A STEWART State of Maryland / Department of Health and Mental Hygiene MHW 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 430, 2004 **Physician** 3:05 P M JOHN PAUL ALFRED STEWART /Medical 4a. Fecility Name (If not institution, give street and number)
419 ALAMEDA PARKWAY 4b. City, Town, or Location of Death ARNOLD 4c. County of Death
ANNE ARUNDEL CO Examiner If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 1 🛣 M 2 🗆 F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 265-20-9536 78 Yrs. Director -3-1926 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Itams 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 No GLEN BURNIE MD ANNE ARUNDEL Directo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1101 McHENRY DRIVE 21061 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: SpecifWHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES AUTOMOTIVE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental H HAROLD GRIFFITHS STEWART SARAH DUNNINGTON POOR Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Itam 27 is
any injury or other trau MRS. ELIZABETH W. STEWART/ WIFE 1101 McHENRY DRIVE, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/6/2004 BALTIMORE, MD GREENMOUNT CEMETERY * 4 □ Donation 5 □ Other (Specify) 21. Signatu e of Forteral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVENUE S.W., GLEN BURNIE MD 21061 molLe firt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a I mediate Cause (Final disease or condition resulting in death) Physician Cardiovasalar Due to or as a consequence of): Athurosclerotic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of): Physician/Medicai as attending IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the o 9 Unknown 9 Unknown signed by t ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 1 Yes 2 □ No 24a. Was an autopsy performed? Jas page 2 certificate I 1 Yes 2 No of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE XXYes 2 No 2 this funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Hospital or Attending

within 24 hours a

29b. Signature and title of certifier

29c. License number OCME

29d. Date signed (Month, Day, Year) OCTOBER 1, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

DCT 0 2004

Pamela E. Southail, MD



Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legible.							
State of Maryland / Department of Health and Mental Hygiene								
Certificate of Death	Bea No O O							

		For	State of Ma	ryland /	Depa	irtment of H	lealth and M	Mental Hyg	jiene	9.2.0.			
		State Registrar			Cer	tificate of	Death		Reg. No. () () 1 3 7 4 8				
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Examin		4a. Facility Name (If not institution,	1 2 11			1 11	Location of Death)	4c. C	ounty of Death	NI / A		
1		5. Social Security Number		(in yrs. last i	birthday)	Baltimo If Under 1 Year	re Lify If Under 24 Hrs.	8. Date of Birth	irth P. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)				
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and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				1	0d. Inside City Limits		
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fter de	Fune	11. Marital Status 1 □ Never Married 2 🛣 Marrie	12. Was Decedent E Armed Forces? ad 1 X Yes 2 □ N		Д	Vas Decedent of H f Yes, specify Cuba		o Rican, etc.)	14	Black, White,	etc.		
72 hours after dea neturel; or Items	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			I□Yes 21X No	Specity:			pecify:	WHITE		
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2 shoute and Me is mark	To	19a. Informant's Name/Relationsh	ip (Type, Print)		9b. Mailin	g Address (Street	and Number or Ru		-		Code)		
is 1 and 2 of Health item 27 other tre		SONYA SUGARMAN	I / WIFE	20b. Place		HAWTHORNE sition (Name of natory or other place		- PIKESV		, MD 21 ition - City or To			
Pages ent of I		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				natory or other plac CHAIM (AD				OSEDALE			
permit. Pages 1 and 2 Department of Health Importent: If item 27 eny injury or other tr		21. Signature of Funeral Service L			22	Name and Addre	ss of Facility SO	L LEVINS	ON &	BROS.,	INC.		
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/Medical Examiner		resulting in death)	Due to (or as a	114	,	whic leader	ed it						
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	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature									
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			1_ State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death										
I	Physici	an	Decedent's Name (First, Middle, Last) WINSLOW LEE	Decedent's Name (First, Middle, Last)										
	/Medic Examin		4a. Facility Name (If pot institution, give street and numb 1	er) Hospital Age (In Vs. last birthday)	4b. City, Town, or Loca	ation of Death	ity	Ic. County of Death	A place (State or Foreign ntry)					
	Director		212-34-7513 1√2 M 2 □ F Usual Residence of Decedent	65 _{Yrs.}	Months Days Hor	urs Min.	Date of Birth (Month, Day, Yea 2 21	1939	MD					
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If tiern 27 is marked other then "natural", or items 23e or 28e-f show importent: If tiern 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, Ite Marical Eventral terrollised at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Never Married 12. Was Decede Armed Force 1 Yes 2 If Yes, Give	R No I	Was Decedent of Hispani f Yes, specify Cuban, Me I ☐ Yes 2☑ No Spe	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black							
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Baltimore,	Pages 1 nent of Hi ant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	ara i	mel Cem.	Date 10-9-		Location - City or To Baltimor						
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وللا	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death) a	sed the death. Do not enter	101 E. No. er the mode of dying, suc STRUCT? V	ch as cardiac or re	spiratory arrest,		MD 21202 Approximate Interval Between Onset and Death					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yee **Physician** Robert Thomas 33 PM rober 3004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Jenera N/Ahad! trimae 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 242-44-5946 73 Director 08-02-1931 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 □ No N/A Md Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2850 W. Garrison Ave. 21215 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify:Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than 12 years College (1-4or 5+) Crane Worker Beth. Steel other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ocy Thomas Addie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Thomas/ Wife 2850 W. Garrison Ave.Balto., MD. 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or injury or * 4 ☐ Donation 5 ☐ Other (Specify) King Park 10/09/04 Randallstown, MD 21. Signatule of Funeral Service Licentee 22. Name and Address of FacilityHowell Funeral Home 4600 Liberty Heights Ave.Balto., MD.21207 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 76 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a signed t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has ormed? 2 No certificate ! 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical director 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RANGANATHAN MANAHERM MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ranganothor 10

DHMH 17 Rev 1/2001

State

Registrar

OCT 07

2004

31. Date filed (Month,

PAJUAN OU

32. Registrar's Signature

Christopher Turner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#24a.perVFrbal MF G838 12/29/04 TT
State of Maryland/ Department of Health and Mental Hygiene

1- State Unpend Item 23a&27 per me G839 1-25-05 tas

Reg. No. 1 1 04-06341 **RPD** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October I, 2004 **Physician** 1015 P M Christopher Scott Turner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F Months 26 Director 225-45-2593 Ohio Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner mat be notified at 1 Yes 2 No Director MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ŏ or Itams 23a 18609 Chickadee Lane 20879 United States Be Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. □Yes 2X No Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: "natural" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. N/A Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental P Pages 1 and 2 should be Scott Rhombach Turner ပ Debra A. Carrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Debra A. Johnston/Mother 4 Forest Brook Ct., Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Oct 6 permit. Page:
Department o
important: If any injury or
once. ŏ * 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 2004 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licens Steple D 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seizure Disorder /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, lany, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy rmed? 2 \Box 1√2 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 ☐ No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending investigation 1 TYes 2 No death after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1801 IMW O.C.M.E. October 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYAMOR Kolloth 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 0 7 2004 Registrar

			For Stete Registrar		State of	of Mary	/land /		rtmen tificate				ental Hy	giene Reg. No.			1175	2
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day										/ear	3. Time of D	М			
	/Medic Examir		Jean VanM 4a. Facility Name (If not			ımber)			4b. City,	Town, or	Location of	of Death	Octobe		County of		9:45 A	М
	Funeral		Caton Mano 5. Social Security Numb		Sex	7. Age (In	n yrs. last	birthday)	If Under		altir If Under Hours		8. Date of Bi (Month, Da	rth		9. Birthpl Coun	lace (State or I	Foreign
	Director		380-18-874 Usual Residence of Dec		1□ M 2⊠F		89	Yrs.	MOTITIS	Days	nours	IVIII1,	Apr 17		15	MI		
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Evaluation into the Anoles. Once.	-		b. County	_	10	c. City, To	own or Lo	cation							10	0d. Inside City	
		Director	MD N/A Baltimore									at Coun						
10		Funeral D	1622 Hollin	12. Was Dec Armed F	Yes 2 TNo			21223 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I				cify Yes or No Rican, etc.)		ited States 14. Race - American Indian, Black, White, etc.				
9600		by	3 ☐ Widowed 4 🔀	Divorced	If Yes, G Year or I	or Dates:			1 ☐ Yes 2 ᡚ No Specify:					Specify: White				
21215-(Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1						ng	16b. Kind of Business/Industry Own Home								
/land		To Be C	17. Father's Name (Firs										(First, Middle		Sumame))		
Mary	d 2 sho th and I to is me traums		19a. Informant's Name Phyllis Va			aught.							<i> Route Numb</i> altimor				Code)	
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altin			4 □Donation 5 □ 21. Signature of Funera				Ches	22	ke Cr	d Addres	s of Facilit	ty	004		svil	•	MD	
	원리트 등 경 Physician		Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD 23a. Part. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. — Due to (or as a consequence of): Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death Onset and Death															
	/Medical Examiner		resulting in death) Due to (or as a consequence of): D(SC154)															
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A Division of Vital	I or Attanding Pater death. I Director: After id in by the funera	Certification:	1 PMatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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	To the within to the comp	Σ	29b. Signature and title of certifier 29c. License number 29d. 29c. License number 29d. 29c. License number 29d. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURVA P-MUNDLA MD 8021 LIZEHE (PWY MS)										Date signed (Month, Day, Year) TUBGL 5, 200 4					
	3		30. Name and address	- MI	o completed cau	use of death		a) (Type,	Print)	70	HIE	(~	wy 1	15/	TPE	NA	Me	٥ .
	Sta Regist	ate rar																

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death OCE. 2004 **Physician** 5 Wakefield Evelyn 8:350 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HArford 927 CandleLight Court BelAir If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Feb. 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 M 2 X 1934 70 219-30-0108 Maryland Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits or 28e-f ehow or other treumatic event, the Mudical Examiner must be notified at MD Harford BelAir 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21015 USA 927 CandleLight Court or Items 23s by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Item eny injury or other treuments. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 SpecifWhite 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Americo Giorilli Anna Vendetti ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7057 Eastbrook Ave. Baltimore MD 21224 Donna Wise /daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
BayviewCrematory 1 Burial 2 Cremation 3 □ Removal from State 10/9/04 Baltimore MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sai CMCr Physician 5 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ Month Year in the past 12 months?
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Tes 2 Hospital: Other: 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deatl 28b. Time of 28d. Describe how injury occurred Certification: the Hospitel or Attending hin 24 hours after death. the Funerel Director: After 1 Natural 2 Accident 5 Pending investigation 2 No 1 Tyes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAHUMA KOAD # 9512 AL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 7 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Yeer Day Physician 24 MARIAN ELAINE ADAMS Sept. 2004 1022 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cîty, Town, or Location of Death **Examiner** Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ▼ F May 18, 1922 Michigan Director 372-14-0029 82 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mantal Hygiene.
and: if Item 27 is marked other than "natural", or Items 23a or 28a-f show and 70 or other traumatic event, it is Marifall Exp. eling 1. stall by multiliad at uny or other traumatic event, it is Marifall Exp. eling 1. stall by multiliad at 1 ☐ Yes 2 XNo Completed by Funeral Director MD Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1082 Ocean Parkway 21811 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. I ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Financial Analyst U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Einar Kurtti Florence Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kurtis P. Adams 5 Morning Mist Dr., Ocean Pines, Md. 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10-12-04 1 Surial 2 Cremation 3 Removal from State permil. Page Department of Important: If any injury or once. 4 Donation Arlington National Cem. Arlington, Virginia 5 Other (Specify) 21. Signatural Seg 22. Name and Address of Facility The Burbage Funeral Home 11002 108 William St., Berlin, Maryland 21811 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician SCVD **#**Medical resulting in death) Due to (or as a consequence of): Exammer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Chicago of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No o 9 Unknown 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, director, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 1 Yes 2 No 1 Tyes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To of this 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 VNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier H0653717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9714 Healthway Berun MATZANZ DRIVE mp Jettry 31. Date filed (Month) Day, Year) 32. Registrar's Signature State 7 2004 2 Registrar

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Phys /Me	ician dical		amuel Albe	rt Sr.			2. Date of Dea Month Sept. 2		3. Time of Death 3:00a M
5	ninei	A. C. What blance When blank had been been			4b. City, Town, or Hagers	Location of Death		4c. County of Washi	Death .ngton
Funer Direct		220-16-2895		(In yrs. last birtho 79 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Aug . 19	, 1925	Birthplace (Stete or Foreign Country) MD
Maryland -fahow	Į	Usual Residence of Decedent 10a. State 10b. County MD Washir	ngton	10c. City, Town of Hagers					10d. Inside City Limits Yar 2 □ No
death with the Maryland me 23a or 28e-f show	Funeral Director	10e. Street and Number 988 Kasinof	Ave.		10f. Zip Code 2174()	1	10g. Citizen of Wh. U.S.A	
I 3-UU.30 172 hours after death with the Marylan 172 hours after death with the Marylan 172 hours after 628 or 286-1 ahow clical Exertings mat the results at	hy Euner	3 ₩ Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	ver in U.S. 5 1943- 1946	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White
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i, Marylan and 2 should be salth and Mental n 27 le marked o		19a. Informant's Name/Relationship Eugene Albert		14	Mailing Address (Street & 1111 Penns			Hagerst	own, MD 2174
DaltImore, permit. Pages 1 a Department of Hea Importent: If Item ■ny injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 Onation 5 □ Other (Spe	cify)	20b. Place of D cometery, Cedar	isposition (Name of crematory or other place Lawn Ceme		. 27, 004	20c. Location - Ci Hagerst	ty or Town, State
Himpod Departing Medic	ลก	21. Signature of Funeral Service Lie 23a. Part 1. Enter the Isease, or or shock, or he in failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that couled hy one cause on each line a.	-UNS	P.O. BOX t enter the mode of dyin	drain mh	ompson or Spri	Funeral	Home, Inc 21722 Approximate Interval Between Onset and Death 7 Months
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The lay							24a. Was a autops perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 \(\sum \text{No}\)
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LIVISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director.	o de de la constante de la con	3 Suicide 6 Could no determin	t be 28e. Płace of Inju ed building, etc.	ry - At home, farm (Specify)	n, street, factory, office		28f. Location (S City or Town		or Rural Route Number,
the Hospi in 24 hour he Funer	Cipo	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner state	examination and/	or investigation, in my o	pinion, death occur	red at the time, d	date and place, and	d due to the cause(s)
TA D		29b. Signature and title of certifier	9. mile	weel /	29c. Licenso	e number	2	29d. Date signed (Month, Day, Year)
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Reg	State istra	AFR A A		r's Signature	Sperti				-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 21,2004 ARON 2,30 a.M Anne Molly 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Months Days Hours Min. Apr. 21, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Months Days 1 ☐ M 2 🕱 F 90 Washington, DC 217-46-5639 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1X Yes 2 □ No VA Leesburg Loudoun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42829 Forest Spruce Drive 20176 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 N Married 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Israel Bachrach Fannie Epstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Aron / son 42829 Forest Spruce Drive, Leesburg, VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Garden 9/22/2004 Olney, MD `4 □Donation 5 □ Other (Specify) 21. Signature of Figural service Ligense 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardio-respiratory arrest disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 X No ence 6 Other (Specify)

Physician /Medical **Examiner** to the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Physician

/Medical

Examiner

by Funeral Director

Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event. The Medical Examinar result be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner physician and the burial-transit Physician/Medical þ Be Completed 2 Certification;

1 □ Yes 2 XNo 9 □ Unknown	9 Unknown	3 Cities (specify)
art II. Other significant condition	ons contributing to death but not resulting	g in the underlying cause given in Part
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25. Was case referred to med	dical
examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hosp
27. Manner of Death	2

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8a. Date of Injury	28b. Time of		Injury at		. De <i>s</i> cribe h

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Manner of Death Natural Control Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d.	Describe how injur	y occurred	
3 Suicide	6 Could not be	28e Place of Injury - At h	ome form stree	t fact	one office		28f	Location /Street an	d Number or	Dural

4 Homicide	determined	building, etc. (Specify)	21
29a. Certifier	10 Certifying Physi	cian: To the best of my knowledge, death occurred at	t

28f. Location (Street and Number or Rural Route City or Town, State)	Number
Only of rown, State)	

(Check only one)	2 Medical Examiner: On the basis of examination and/o							
9b. Signature ap	d title of certifier	///	11	H				

Certifying Physician: To the best of my l	knowledge, death occi	urred at the time, date and place	, and due to the ca	use(s) and ma	nner as state	d.
2 Medical Examiner: On the basis of exam	ination and/or investig	gation, in my opinion, death occu	rred at the time, da	ite and place, a	and due to the	e caus
and manner stated.						
2 /	,	00 1:				

29b. Signature and title of certifier	\mathcal{L}
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30. Name and address of person who completed cause of death (III m 23a) (Type, Print) 1 4 5 5 7 8 2101 East Sefferson St Rakurell HD 20552

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

after death.

within 24 hours a To the Funerel D

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:38PM PATRICIA LEE AUSTIN SEPTEMBER 18, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax **Funeral** Days 1□M XXF Months 63 Yrs. 577 54 5983 08, 1941 WASHINGTON, DC Director APR. Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at XX Yes 2 No MARYLAND PRINCE GEORGES FORESTVILLE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8503 CORONA STREET 20747 UNITED STATES death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married XX Marned Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK ð 3 ☐ Widowed 4 ☐ Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than the Coltege (1-4or 5+) Elementary/Secondary (0-12) 2YRS. STATISTICAL ASSISTANT FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Ospardment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event SDRs. 17. Father's Name (First, Middle, Last) Be FLOYD JOHNSON ANNIE HEIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE S. AUSTIN / DAUGHTER 8503 CORONA ST. FORESTVILLE, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEM. 9-23-04 CHELTENHAM, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD nawara 4308 SUITLAND RD. SUITLAND, MD 8 23a. Part1. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DIABETES The law requires that the death certificate be executed 20 YEARS physicien and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð END STAGE RENAL DISEASE ON DIALYSIS 3 Probably 4 ☐ Unknown 2 No Completed peen SEVERE PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 24 No certificate has page 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA Certification: To this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Xatural 5 Pending 1 Tyes 2 No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and margin stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 21883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9670 ANNAPOLIS Road Scrife #315 LANHAM · YADLAM.D HEMA 31. Date filed (Month, Day, Year) Registrar's Signature State 24 Registrar

DHMH 17 Rev 1/2001

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Division of	or Attand after death Director: / I in by the f	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. lace of Injury - A	~ 2115	1			8f. Location (St	reet and N	-	ral Route Number,
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	4	•			Certificate of			Reg. No.) [31759				
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Funeral Director		215-42-3538	Sex 7. Age (In 1	yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Date)	th Year) 44	9. Birth	place (State or Foreign ntry)				
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		30. Name and address of person who Howard N. Weeks			Type, Print) rn Ave. Hag	erstown,	MD 2174	2						
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SEP 2 4 2004

Registrar's Signature.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician NATHAN 1750 BRESKIN SEPTEMBLE way /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Maritaner HOUT CLOSS HOSPING SILVER SPACE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F Days Hours NOV 1, 1918 WASHINGTON, DC Director 85 578-10-3422 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28e-f show the Modical Expedient dust be notified at 1 √Yes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 20901 UNITED STATES 9511 SAYBROOK AVENUE 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) LAWYER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fand Mental ROSE HARBIN DANIEL BREESKIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 siment of Health an ent: If item 27 is r 6008 AVON DRIVE, BETHESDA, MARYLAND ROBIN LEVIEN, DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Importent: If it
any injury or o 1 🕅 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) MT. LEBANON CEMETERY 9/21/2004 ADELPHI, MARYLAND 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 take or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part. Enter the disesship k, or heart failu e. Immediate Cause (Final EXSANGUIDATION FLOM DIALYSIS CATHEREL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENO-STATE DENK OUSERSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine AMPENIOSCEPIONE CARDIOLASCUCIAL DISEASE The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 2 X No Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) uneral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending FOR TO FLOOR - DILLOUGOD CAPPS 1 ☐ Yes 2 ☐ No seetenber 18 cm investigation 11700 death. 2 Accident OF UMISS CATHERE completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō GEN SATEROSE DR. SILVESTATE / NO \$ 10 ME within 24 hours a To the Funerel (To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 18, 2004 KUD, (OHE) 015256 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Char I. Margoris Mo IMS Bocksier Pikt, Rocksier, MO 2088 31. Date filed (Month, Day, Year) 32. Registrar's Signature State socks! 2004 My

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

			For State Registrar	State of	Marylar	-	artment e tificate			nd M	ental Hy	giene	004		11762	2
	Divt-t		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea				3. Time of Dea	ath
	Physici /Medic		Maria	Barrer	a						Septemb	-		ear 004	7:25 P	M
	Examin	er	4a. Facility Name (If not institution, give	e street and num	ber)		4b. City, To	wn, or l	Location of	Death		4c.	County of	Death		
			12604 Bridgeton					coma					lontg			
	Funeral Director		5. Social Security Number 6. S	ex □M 21x0F	'. Age <i>(In yrs</i> . 9	O Yrs.	If Under 1	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Pa) June 16	h v. Year)	14	. Birthpl Count Braz	ace (State or Fo	reign
			218-56-8786 Usual Residence of Decedent								oune 10	, 10	14	braz	71	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Li	imits
	Mar.	cto	Maryland Montgo	mery	Po	otomac									1 ☐ Yes 2 X] No
	or 28	Director	10e. Street and Number				10f. Zip Ci	ode				10g. Citiz	en of Wh	at Count	try?	
	ath w		12604 Bridgeton	Drive			208						Cul	oa _		
	er de	Funeral	11. Marital Status	12. Was Deced	es?	.S. 13. \	Vas Deceden f Yes, specify	nt of His Cuban	panic Orig , Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	- 1	 Race - Black, 	America White, e		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Da			Yes 2	□ No	Specify: E	Braz:	ilian		Specify: [Whit	е	
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show tes M. cirel Ex. nither i, ust by challfied at	led	15. Decedent's Ed	ducation		16a. Deced	ient's Usual (Occupat	tion			16b. Kin	d of Busir	ness/Ind	ustrv	
215	hin 7;	Completed	(Specify only highest gra	de completed) College (1-	4or 5+)	(Give	kind of work of OO NOT use	done du retired)	uring most	of worki	ng					
21	giene giene er the	mo:	12	College (1-	401 34)	Sea	mstres	ss				Clo	thing	ı Re	pair	
g	ai Hy ai Hy 1 oth	Be (17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,					
yla	Ment Ment arke	10	Manuel Madureira	1					Con	suel	o Perez	2				
Maryland	2 short and is m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (S	Street ar	nd Number	or Rura	l Route Numbe	r, City or	Town, Sta	ate, Zip	Code)	
	l and fealth im 27		Maria A. Sontheim	er/Daug		12604 Place of Dispo			n Dri		Potoma				0	
Baltimore,	if ite		20a. Method of Disposition ★☑ Burial 2 ☐ Cremation 3 ☐		tate G	cemetery, cren ate of	natory or other Heaven	er place, n	Se		nber 24	20c. Loc	eation - Cit	y or I ov	vn, State	
量	rtmer rtant		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer			Cemete	erv				04 8	ilve	r Spr	ing	, Maryla	ınd
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural; or itema 23e or 28e-f show may injury or other traumatic event, the Michael Examiner and be cullified at ance.			1 Po		Fi	ancis	Address	CO11	ins	Funeral	Hon	e in	c.	WD 000	001
			23a. Part1. Enter the disease, or com	olications that ca	used the deat		JO OIII	VELS	STCA 1	ььчи	, w., S	irve	r sp	ring	Approximate	901
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ch line.			-, -,							Interval Betweer Onset and Deat	n h
	Physician /Medical		disease or condition resulting in death)	a Cardio	pulmon		rest							_		
н	Examiner						B									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Arteri Due lo (o	ras a conseq	tiones of).	eart D	ise	ase							
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c. Alzhei	mer's											
ő	rate be executed physician and the burial-transit	I Ex	resulting in death) Last		r as a conseq	uence of):										
8760,	icate be executed physician and s the burial-transit	dlcat		_{d.} Inanit	ion									-		
9 xo	death certific e attending p od for use as	/Me	IF FEMALE:	age If was outer	and of program									1		
Bo	eath certifii attending p for use as	lan	23b. Was decedent pregnant in the past 12 months?		th 2 □ Feta nt at time of d	Ideath 3	Ectopic pregi					23	3d. Date o Month		y Day Year	
o.	that the deed by the detached	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		oatii 5	Other (speci	·y)								
₾.	res that the signed by be detaction	by Physician/Me	Part II. Other significant conditions c	ontributing to dea	ith but not res	ulting in the ur	iderlying caus	se giver	n in Part I.		23e. Did to	bacco us	e contribu	te to the	cause of death	1?
Records,	quires n sign	d b									1 □ Y	es 2X	No 3[] Proba	bly 4 ∐Unkn	own
၀	s been si s should	olete									24a. Was a	an	24b. Wer	e autop	sy findings avail	able
Re	The law requires that the rate has been signed by the page 2 should be detache	Completed									autops	med?	prio dea	r to com	pletion of cause	of
Vita		a l	25. Was case referred to medical				<u> </u>		26. Place o	of Death	1 ☐ Yes (Check only or	2 ½ No ne)		105 4	: [140	
+	S =	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ In	patient 2	ER/Outpatien	3□ DOA	Other			ne 5 🙀 Reside		Other (Specify)		
0	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	28c.	Injury a		_	8d. Describe h					
Division of	r Attending Phy ter death. irector: After thi by the funeral of	Certification:	2 Accident investigation				М		es 2□N	0						
Ž	i or Attenc after death Director: in by the	ı İ	3 Suicide 6 Could not be 4 Homicide determined	286. Place 0	f Injury - At ho J, etc. <i>(Specil</i>)	ome, farm, stre	et, factory, or	ffice		2	8f. Location (Si City or Town	treet and n, State)	Number o	or Rural	Route Number,	
	ospital or A hours after uneral Dire ly filled in by		00- Cartier HE Cartie - Dt							1						
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	edical	29a. Certifier 1X Certifying Ph (Check only 2 ☐ Medical Exan	ysician: To the bas niner: On the bas and manne	is of/examina	wieage, death tion and/or inv	occurred at t estigation, in	me time my opii	e, date and nion, death	piace, a occurre	nd due to the c d at the time, d	ause(s) a late and p	ind manne place, and	er as sta due to t	ted. he cause(s)	
	To the Hi within 24 To the Fi complete	Mec	29b. Signature and title of pertifier	and manne		/	29c. L	icense i	number		2	9d. Date	signed (A	fonth, D	ay, Year)	
			11118	my for	MAR	110	7		Ini	510	,	Sent	ember	. 22	2004	
	3		30. Name and address of person who	completed cause	of death (Item	1 23a) (Type 1	Print) Na 3	202	T	1110		1, 3,				
			30. Name and address of person who	St no	wh	Jash	DC	2	200	6	100-	296	34	140	7	
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa		Spar									
	Registr	ar	SEP 23 20	114	pera	1	Mou	22/								

		1 - For Amend Registrar 1. Decedent's Name (Fin			-	00	inicate	011	Jeani		lental Hyo		1114	3. Time of Death
Physic	ian	Donald										nber 13	3. 2004	7:00pm M
/Med Exami		4a. Facility Name (If not			er)		4b. City,	Town, or	Location of	of Death	Борос		ty of Death	7.00P.m
		Washingt	on Adv	entist Ho	ospita	1	Т	akom	ıa Paı	rk		Mon	tgomer	У
Funeral		5. Social Security Number	er 6.5			last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da)	h y, Year)	9. Birthp Coun	ace (State or Foreign
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/land			o. County		10c. Cit	y, Town or Lo	ocation						11	Od. Inside City Limits
Mary 9-f sh	to	MD M	lontgom	ery	S	ilver	Sprin	g						1 XYes 2 No
within 72 hours after death with the Maryland ane. ane. then "neturel", or Itams 23a or 28e-f show he Madical Examiner must be notified at	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen o	f What Coun	try?
ath w	ral	9727 Mt.	Pisga	7				0903					d Sta	
er de Itams	Funeral	11. Marital Status		12. Was Decede	es?	.S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	ispanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ ack, White, (
irs aft	by F	1 ☐ Never Married 3 ☐ Widowed 4 ื🌂	_	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	2 ∑X No	Specify:			Spec	ify: Blac	ck
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be find H	Be	17. Father's Name (First)							First, Middle,		ame)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Itams 23a or 28e-f show any injury or other traumatic avent, the Madical Examples in usibe notified at any injury or other traumatic avent, the Madical Examples in usibe notified at any once.	70	19a. Informant's Name/		Type, Print)		19b. Maili	ng Address	(Street a			Jackson		n State Zin	Code)
nd 2 s Ith an 27 is		Carlos Bo		Son			•				V. Washi			0000)
s 1 ar f Hea item othe		20a. Method of Dispositi	ion			Place of Dispo	sition (Nam	ne of			Date	20c. Location		wn, State
Dermit. Pages 1 a Department of Hea mportent: If item any injury or othe		1 🔀 Burial 2 □ Cr `4 □ Donation 5 □	emation 3 []Other <i>(Speci</i>]Removal from Sta fy)	11 9	nco1n				9-20	0-04	Suitl	and, MI	
permit. Departm Importe any inju		21. Signature of Funera	I Service Lice	пѕөө	A-	2:	2. Name and	d Addres	s of Facilit	ty Dona	Funove	1 Uomo		
88588		Xelor	na.	$m \propto a$	wo	2	617 P	enn.	Ave S	. Fope	Funera Washing	ton DC	20020)
		23a. Part1. Enter the di shock, or heart fail	isease, or com lure. List only	plications that cau one cause on eac	sed the deat h line.	h. Do not en	ter the mode	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Fina disease or condition	el .	S	EPSIS	SYNT	pron	15						Onset and Death
/Medical Examiner		resulting in death)	(Due to (or	as a conseq	uence of):	J PN	1511	A A A A /	71				*
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be executed ician and burial-transit	Examiner	resulting in death) Last		c. Due to (or	as a conseq	uence of):								
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The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:										1		7-7-
ath ce	lan/	23b. Was decedent pre- in the past 12 mos			1 2 ☐ Feta	Idéath 3[Ectopic pre						ate of delive	ry Day Year
he de the a	yslc	1 ☐ Yes 2i ☐ No 9 ☐ Unknown		4∐Pregnan 9☐Unknow	t at time of d n	eath 5L	Other (spe	ecify)		-				,
that the	/Ph	Part II. Other significan	t conditions	contributing to deat	h but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	bacco use co	ntribute to th	e cause of death?
uires n sign lld be	d b	PRESSURE	SORE.	SACRUM	, GA	ts mo/	MITT	MA	1		1 🗆 Y	es 20 No	3 🗌 Proba	ably 4 Unknown
he law requires t e has been signe	lete	RUEDING.	CIM	HOSIJ OF	LIVET	2, EN	US CLI	HUE	RENA	L	24a. Wasa	an 24b	. Were autor	sy findings available
sician: The law certificate has b irector, page 2 s	Completed by	DUDKEDA	-			MAL V.					autop perfor	sy	prior to con death? 1 \(\sum \) Yes	pletion of cause of
	BeC	25. Was case referred to		,	1-11-10	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0-00	/ 0			1 ☐ Yes		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
Physician: T rthis certificate ral director, pa	To E	examiner?		Hospital:	atient 2 🗆	ER/Outpatier	nt 3□ DO	A Othe	er: 4 □ Nu	ırsing Ho	me 5 Resid	ence 6 🗆 O	ther (Specify)
Attending Physician: The Ir death. sector: After this certificate he by the funeral director, page	i.i.o	27. Manner of Death	Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o	f 21	Bc. Injury Work	at ?		28d. Describe h			
Attendia death. ctor: A y the fu	catl	2 Accident	investigation				М		Yes 2	_				_
I or Attending after death. Director: After	artif	4 Homicide	determined	200. Flace UI	Injury - At he , etc. (Specify	ome, farm, sti	reet, factory	, office			28f. Location (S City or Tow		iber or Rural	Houte Number,
To the Hospital or Attention within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification;	29a. Certifier	Certifying P	nysician: To the be	est of my kno	wledge deat	h occurred s	at the tim	e date an	d place	and due to the o	eause/s) and n	nannar ac et	ated
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To the within Fo the somple	Me	29b. Signature and title	of certifier	^	1		(74)		number		2	29d. Date sign		Day, Year)
		> K.	Suya	ensure	an		1)53	3367	1		9/13	104.	
R (3)		30. Name and address of	of person who	completed cause (of death (Item	123a) (Type,	Print) (9AT	MEN	rizur	G, MP	: 2087	 	
St	ate	31. Date filed (Month, D	000		istrar's Signa	iture								
Regis	rar	SEP 2	2 4 200	4	e St	400	We !							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year ERNEST R. BREWINGTON SEPTEMBER 20, 2004 11:55 p^N /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **X** M 2□ F 229-01-8136 SEPT. 7, Director 1920 VIRGINIA Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exampler must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4705 LANCE COURT 20853 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married XYes 2 No NAVY Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No lf Yes, Give Yawwor Date&KOREAN Specify ş 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS PILOT NAVY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BREWINGTON VIRGIE LEE BROOKS CALVIN EARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4705 LANCE COURT, ROCKVILLE, MARYLAND DIANE S. BREWINGTON - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ▼ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 9-23-2004 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service I 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Donald. 23a. Part 1. Enter the disease, or complications that caused the described by the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 Days disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner 4 Days Cholecystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be execufed the burial-fransit 10 Days **VFib** Arrest that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Years Cardiomyopathy Physician/Medical as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ed by the atter detached for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2X No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia has autopsy performed? **X**□ No 1 Yes 1 🗆 Yes Division of Vital Cerebrovascular Infarct 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ▼ Inpatient 2 □ ER/Outpatient - 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending Patter death. 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number DU061856 auso, MD

Registrar

30. Name and

23 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Heather Lorenzo, M. D. 9901 Medical Center Drive, Rockville, Maryland soukes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrer		State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of		•	giene Reg. No.?	1 766
	•	w kije	1. Decedent's Name	e (First, Middle, La	st)				2. Date of Dea		3. Time of Death
	Physicia /Medic		Robert	Micha	el Broo	mhead			Septemb	er 15. 20	004 9:28 A M
	Examin	-	4a. Facility Name (I	f not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County of D	Death
			Shady Gr 5. Social Security N		ntist Hosp	tial ge (In yrs. last birthday	Rockvi		8. Date of Birt	Montgame	Rightless (State or Foreign
	Funeral Director		078-82-69 Usual Residence of	991	X M 2□ F	56 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 1, 1948 E	Birthplace (State or Foreign Country) Ingland
	land ow		10a. State	10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan e-f show	tor	Maryland	Montgom	ery	Rockvil	1e				1X Yes 2 No
	in the	irec	10e. Street and Nur	nber			10f. Zip Code			10g. Citizen of Wha	t Country?
	23e 23e	la	9927 A	lta Sprin	gs Way		2085			England	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show many injury open the treumette event. If it Modical Evantice from the notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2 <mark>X</mark> Married 4 □Divorced	12. Was Decedent Armed Forces? 1 Tes 2 M If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2K No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 14. Race - / Black, V Specify:	American Indian, Vhite, etc. White
5-0	72 hc	Completed by	(Spec	15. Decedent's E	ducation ade completed)	16a. Deci (Giv	edent's Usual Occup e kind of work done	pation during most of work d)	ing	16b. Kind of Busine	ess/Industry
121	within ne.	ш	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		of Sales	1	Computer	4
	Hygie Hygie ther t	ပိ	17. Father's Name	(First, Middle, Lasi	<u>4</u>	VICE	rresident			Maiden Sumame)	
lan	d be ental ked o	To Be		Lewis Br				Phyllis	Gleave	2	
Maryland	shoul	۲	19a. Informant's Na			19b. Mai	ling Address (Street	and Number or Run	al Route Numbe	er, City or Town, Sta	te, Zip Code)
	and 2 alth a 27 is		Christi	ne E. Br	oomhead /	Wife 9927	Alta Spi	cings Way	Rockvi	ille, Mary	land 20850
ore,	of He of He		20a. Method of Dis		Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla		Date 22	20c. Location - City	or Town, State
i	Page ment			5 Other (Speci			itan Crem	atory 200		Alexandr	ia, Virginia
Baltimore,	permit. Departimport. eny inj		21. Signature	ineral Service Life	nsee		22. Name and Addre	ess of Facility De Park Dr.		eral Home ersburg,	
	+		23a. Part1. Enter t shock, or hea	he disease, or con	plications that cause one cause on each I	d the death. Do not er ine.	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause disease or condition resulting in death)	(Final		derotic Co					Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as	a consequence of):					
ш		ā	Sequentially list co	nditions,	b Due to (or as	a consequence of):					
	nted I Insit	min	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	erlying injury	·	. ,					
Ć,	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death)	Last	C. Due to (or as	a consequence of):					
68760,	icate be ex physician s the buria	edical			d						
-	g b		IF FEMALE:								
P.O. Box	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ☐No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
	s that ned by e deta	y Ph	Part II. Dther signi	ficant conditions	contributing to death t	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
Records,	en sig	Completed by							1 🗆 🗅	Yes 2□No 3□	Probably 4 Unknown
900	2 5	plet							24a. Was	an 24b. Were	e autopsy findings available to completion of cause of
	The I	Com							perfo	rmed? deat	h? Yes 2□ No
/ita	sicien: Th certificate rector, pag	Be (25. Was case references				100	26. Place of Deat	h (Check only o	nne)	
of \	Phys this al diu	To	1 Yes 2		Hospital: 1 Inpati		NII JU DON			dence 6 Other (Specify)
Division of Vital	ding After fune	Certification;	27. Manner of Deal	5 Pending investigation	(Month, Da	ay Year) Injury	Wo	rk?]Yes 2 _No	Zou. Describe i	low injury occurred	
isi	Attending r death.	fical	2 Accident 3 Suicide	6 Could not l	OB Place of In	ijury - At home, farm, s					r Rural Route Number,
Ω	after after Dire	erti	4 🗌 Homicide	determine	building, e	tc. (Specify)	,,		City or Tov	vn, State)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)			of my knowledge, dea of examination and/or i tated.					
	o the vithin	Me	29b. Signature and	I title of certifier			29c. Licen	se number		29d. Date signed (M	fonth, Day, Year)
	J.			hing 1	13. m. D	•	0.C.	M.E.	9	September	16, 2004
	7		30. Name and add	ress of person who	completed cause of	death (Item 23a) (Type	, Print)				
_					. M.D		111 Penn	Street.	Baltimo	re, Maryla	and 21201
:	Sta Regist		31. Date filed (Mor	nth, Day, Year) P 2 3 20		rar's Signature	Sparks	1		-o, imyte	MAY CICUI

68760,
Вох
P.O.
Records,
Vital
of
Division

		Please Type or Pri	nt in Black In aryland / Dep			-	_	
		1 - State Registrar		rtificate of		Reg. I	2001	31766
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physici /Medio		John Leroy Baker			5	eot. a	$rac{7}{2}$	2026 M
Examin		4a. Facility Name (If not institution, give street and number)	-1,	4b. City, Town, o	r Location of Death		4c. County of Deat	1
		Memorial Hos	PITAL Je (In yrs. last birthday)	If Under 1 Year	ASTON If Under 24 Hrs.		IAL	pot
Funeral Director		222-26-3644		Months Days	Hours Min.	3. Date of Birth (Month, Day, Yes 8/2/1944	ar) 9. Birt Co	hplace <i>(St</i> ate or Foreign untry) 'land
		Usual Residence of Decedent				0/2/1744	rary	Tana
arylan show	_	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
98 -4 S	ecto	Maryland Caroline	Greensbor					1 Yes 2 No
with t	ä	10e. Street and Number 27821 Ellwanger Road		10f. Zip Code 2163	0	10g.	Citizen of What Co USA	untry?
ne 23	Funeral Directo	11. Marital Status 12. Was Decedent	Ever in U.S. 13.			ify Yes or No-	14. Race - Ame	rican Indian.
or Ite		1 Never Married 2 Married 1 Yes 2	No		lispanic Origin? (Spec an, Mexican, Puerto Ri	ican, etc.)	Black, White	
Single Si	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1963-66	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of working	16b.	Kind of Business/	ndustry
withir ene.	duc	Elementary/Secondary (0-12) College (1-4or s	Electi	DO NOT use retired Cician	2)	Doz	ver Air F	orce Base
Hygi other	0	17. Father's Name (First, Middle, Last)			18. Mother's Name (orec base
Vialid uld be fil Aental H rked oth tic even	To B	Thomas Chester Baker, Sr.			Pauline C	haffinch	Baker	
DESILITIOTE; INIGITY IGNITY A I A 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other treumatic event, its Medical Exam far musics notified at anone.		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural i	Route Number, Cit	y or Town, State, Z	ip Code)
and and m 27 m 27 her tr		Virginia Usilton Baker/spo			er Road; G			
ges 1 at of H ar ite or ott		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State		matory or other place	· 1		Location - City or	
allillor mit. Pages partment of portent: If it y injury or o		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			ion 10/01		ester, Ma	·
Department Department		21. Signature of Pulleral Service Electises			d Helfenbe			PA
		23a. Part1. Enter the disease, or complications that caused	the death. Do not ent		Greensbor		039	Approximate
Physician		shock, or heart failure. List only one cause on each li Immediate Cause (Final	sepsis					Interval Between Onset and Death
/Medical		disease or condition resulting in death) Due to (or as	a consequence of):					
Examiner		Sequentially list conditions b.	Cetinary	tract	Infectio	ク		
sit ad	iner	cause. Enter Underlying	a consequence of):					
and I-tran	Examiner	Cause (Disease or injury that initiated events c	a consequence of):					
be ex sician a burial								
The colores that the death certificate be executed. The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	d						
box sath cert attending for use	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy			23d. Date of deli-	very
death	sicia	1 Yes 2 No		Other (specify)			Month	Day Year
at the d by the etache	Physician/M	9 Onknown						
res th signed be d	ρ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		/	the cause of death?
necorus, he law requires e has been signinge 2 should be	Completed	7				1 🗌 Yes		bably 4 Unknown
has l	mpl					24a. Was an autopsy performed/	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
vitali ician: Th certificate ector. pa	e Co	25. Was case referred to medical				1□ Yes 2☑N		2 No
veicia s certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatie	ont 2 ☐ ER/Outpatier	t 3 DOA Othe	er: 4 ☐ Nursing Home		6 DOther (C-se	
g Phy g Phy ler this neral c		27. Manufer of Death 28a. Date of Inju	ry 28b. Time of			d. Describe how in		ny)
Attending at death. Sector: Atte	atio	2 Accident investigation	, roar, many		Yes 2 □ No			
or Att	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inj building, et	ury · At home, farm, str c. (Specify)	eet, factory, office	28	Location (Street and City or Town, Sta	and Number or Rui ite)	al Route Number,
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.								
Hoe 24 ho Fune stely f	edical	29a. Certifier 1 Certifying Physician: To the best (Check only one) 1 Medical Examiner: On the basis of and manner set	examination and/or in	occurred at the time vestigation, in my of	ne, date and place, and pinion, death occurred	d due to the cause(at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
o the	Me	29b. Signature and title of certifier	1100.	29c. License	e number	29d. D	ate signed (Month	. Day, Year)
F > F 0		Hasou La	ura Sin	0	55484		9-27-	2004
		30. Name and address of person who completed cause of d						
		Laura Jin, MD 219 S. Wash:	ington Stre	et Easton	n, MD 2160	L		
Sta			ar's Signature					
Registr		SEP 2 8 2004 See	an H	Rock				
בוואורו וו הev 1/20 האורוע	JU I	10 E007	ORIGINA	L				

Physicia /Medica **Examine**

Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - State Registra MEND #24a/bpen		w.mcco Cer	tificate of l		-	Reg. No	1001	31767
1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Da	Yeer	3. Time of Death 2040 M
4a. Facility Name (If not institution, give s	street and number)	-	4b. City, Town, or				. County of Deat	
5. Social Security Number 6. Sex 1/2	7. Age	70 Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bir in. (Month, Da 4 / 2 6			hplace (State or Foreign
Usual Residence of Decedent					3/20/	34	OIC	
10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits
MD Montgon	nery	Silve	r Spring	J				1 ☐ Yes 2 No
10e. Street and Number	_		10f. Zip Code	. 2		10g. Cit	tizen of What Co	untry?
10410 Gatewood			2090				USA	
11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	-	14. Race - Ame Black, Whit Specify: W	
15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of v	working	16b. K	(ind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5	±1	elf Emp			Re	estaura	ant
17. Father's Name (First, Middle, Last)					Name (First, Middle,		•	
Anastasios Kara					nia Kos			
19a. Informant's Name/Relationship (Ty) Georgia Carr/W	· ·				Rural Route Number			್ರಾಂಡ20903 cing,Md
20a. Method of Disposition		20b. Place of Dispo	sition (Name of	.	Date	20c. L	ocation - City or	Town, State
ty Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State		natory or other plac f Heavel		22/04	Si.	lver S	oring,Md
21. Signature of Juperal Service License	IL.	PI	Name and Address	RINALI	DI FUNER	RAL	SERVIC	E,P.A.
23a. Part1. Enter the risease, or compli	cations that caused ne cause on each lin	the death. Do not ent						Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	SERSI	5						Onset and Death
		a consequence of):	w					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
Cause (Disease or injury that initiated events resulting in death) Last	Due to for as	a consequence of):						
	bue to (or as	a consequence on.						
C.								
IF FEMALE:	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
Part II. Other significant conditions con 5 [P SWOKE AL REWN]		ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did t		Le	the cause of death?
519 Survivan Rami					24a. Was autor perfo		prior to death?	ntopsy findings available completion of cause of
25. Was case referred to medical					Death (Check only o	one)		
Yes 2 No	lospital: 1 Inpatie	The second secon		4 LI (VUISII)	g Home 5 ☐ Resi			cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju- (Vont Da)	<i>y Year)</i> Injury	f 28c. Injun Worl		28d. Describe			الا كالاصلى الله كالمالية
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, str c. (Specify)			28f. Location (Street ar	nd Number or Ru	ıral Route Number,
	sicien: To the best	of my knowledge, death	h occurred at the tin		ace, and due to the	cause(s		stated.
	ner: On the basis of and manner sta	examination and/or in			ccurred at the time,			
29b. Signature and title of certifier	MO	(and)	29c. Licens	SZ36			nte signed (Mont	* * * * * * * * * * * * * * * * * * * *
30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type,	Print) with six	5, Recik	ile, no	LEST	V	

State

Registrar

31. Date filed (Month, Day, Year)

SEP 23 2004

Sparker

32. Registrar's Signature

		_	For State	State of	Marylan	d / Depa		f Health	and N	Mental Hy	giene		0.760	
			Registrar 1. Decedent's Name (First, Middle,	Lact		Cei	rtificate d	or Deat		2. Date of Dea	Reg. No.	JUN	3. Time of Death	
	Physicia	an								Month	Day	Year		
	/Medic Examin		Mary Conception 4a. Facility Name (If not institution,		nber)		4b. City, Tow	n, or Locatio	n of Death	Sept.	24,	2004 ounty of Death	<u>5:45 A [™]</u>	_
	Examin	er	St. Mary's Nurs					nardtov				aint Ma	_	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yo	ear If Und	er 24 Hrs.	8. Date of Birt (Month, Da			place (State or Foreign intry)	
	Director		015-10-4657	1□M 2 X F	91	Yrs.	Months Da	ays Hours	Milli.	Mar. 31	19	13 Mass	sachussetts	
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					——	10d. Inside City Limits	
	sho	5											1 ☐ Yes 2 X No	
	28e-i	Director	Maryland St. Ma	ary's	<u></u>	eonard	10f. Zip Coo	de			10g. Citize	on of What Cou	intrv?	_
	3a or		24545 Pin Cush	nion Road			206	50			-	S.A.		
	ms 2	Funerai	11. Marital Status		dent Ever in U	.S. 13.			Origin? (Sp	pecify Yes or No-		Race - Amer		_
ဖွ	after or ite		1 Never Married 2 Marri		2X No		ı res, specily (1 □ Yes 🛣			rican, etc.)		Black, White	, etc.	
8	urel',	d by	3 Widowed 4 □ Divorced	Year or Da								Wr	iite	
<u>7</u>	fled within 72 hours after deeth with the Maryland Hygiene. Ither than "naturel; or Items 23s or 28s-f show ent, Ire Madical Examiner must be rudified at	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usual Oo kind of work do DO NOT use re	one during m	ost of wor	king	16b. Kind	of Business/I	ndustry	
7	withir ene. then	dwc	Elementary/Secondary (0-12) 6th Grade	College (1	-4or 5+)		nstress	,			Тез	vtilo T	ndustry	
р 2	filed Hygiv other ent, II	Be Co	17. Father's Name (First, Middle, I	.ast)					ther's Nam	ne (First, Middle,			nausery	_
<u>a</u>	uld be f fental h rked of	To B	Antone Airozo					Ar	ngeli	na Olive	ira			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Martlard Hygiens. Importent: If item 27 is marked other than "naturel; or items 23s or 28e-f show any injury or other treumatic event, in Madical Examinar must be notified at 200ce.	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (St.	reet and Nun	ber or Ru	ral Route Numbe	er, City or	Town, State, Z	ip Code)	
	1 and 2 Health tem 27 i		Mary Ann Demers	/ Daught									1and 20650	
ore	of Hi		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from	State 20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other	of r place)	1	Date	20c. Loca	ation - City or 1	Town, State	
Ē	Pages tment of tent; If it jury or o		' 4 ☐ Donation 5 ☐ Other (Sp	ecify)			ld-Echo			8-04			all, MD	_
Baltimore,	permit. Page Department of Importent; If any injury or once.		21. Signatur	icensee	MALL	1	2. Name and A						ome, P.A.	_
	40240		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that c	aused the deat	h Do not ent	2955 HO	11ywoc	as mardiac	., Leona	rdtov	√n, Mar	yland 20650 Approximate)
			shock, or leart failure. List	only one cause on e	ach line.			- 1/ -	7.1	от тоорпологу с.			Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a	or as a sense		nom	aro	ROY				6 mis.	
	Examiner			Due to (8	AAZ		ant	120	/			Lun.	
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	cuted	Examiner	that initiated events	c									· ·	
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	that	by Pł	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying caus	e given in Pa	rt I.	23e. Did to	obacco use	e contribute to	the cause of death?	
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DHMH 17 Rev 1/2001

			1 - For State of Maryland / Department of Health and M Certificate of Death		iene g. No. 0 0 4	31770
	Physici /Media Examir	cal	ELIZADETA SULTE UISA	2. Date of Dear Month Septemb	Day Year	
	Funeral Director		Johns Hopkins Hospital 5. Social Security Number 139-26-7169 Usual Residence of Decedent Baltimore City F. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 120-120-120-120-120-120-120-120-120-120-	8. Date of Birth (Month, Oay, Nov. 24	9. Bit C 1933 New	thplace (State or Foreign ountry) Jersey
	n the Maryland r 28a-f show trofffied at	irector	10a. State 10b. County 10c. City, Town or Location	1	0g. Citizen of What C	10d. Inside City Limits 1 □ Yes 2√ No puntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Evarifier must be rediffed at ance.	by Funeral Directo	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:	cify Yes or No-	USA 14. Race - Am. Black, Whi Specify: Whi	te, etc.
121215-0036	iled within 72 ho Hygiene. ther then "natur nt, tre Medical	Completed		Pg A	16b. Kind of Business	
Maryland	d 2 should be the and Mental It is marked of treumatic eve	To Be	Charles Claussen Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	Schaefe	er , City or Town, State, .	Zip Code)
Baltimore,	int. Pages 1 an artment of Heal ortent: If item 2 injury or other		Herbert Dash/husband 20a. Method of Disposition 1	nber	ida 32955 20c. Location - City or Odenton, Ma	
	Physician	0.4	Going Home Cremation MO1251 Beverly L. Heckrotte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	P.A.	Clarksvil	DX 784 Le. MD 21029 Approximate Interval Between Onset and Death
8760,	Medical Examiner Naticieu and provided and	Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to intrindicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Mia		5 Months
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Division of Vital Records,	ding Ph J. After th funeral	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hom 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 2 Accident 3 DOA Other: 4 Nursing Hom 28a. Date of Injury 28b. Time of Injury 4 Work? M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No	8d. Describe ho	nce 6 □Other (Spec w injury occurred	
DİN	ospitel or hours afte ineral Dir y filled in	edical Certif	4 Homicide determined building, etc. (Specify)	City or Town,	use(s) and manner as	stated
1	To the He within 24 To the Fu completel	Med	29b. Signature and title of certifier M.D. RES-0008	75 S	od. Date signed (Month	7, Day, Year) 20 2004
15.) (i) Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHALE D HASSAN JOHNS HOPKINS HOSPITAL 600. 31. Date filed (Months Pay Year) 32. Print Signature	N. WOLF	ESTREET L	Saltimore MO 2128;
	Registr	ar	WI LOUT FORME SO GODILE			

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mary		artment of H			iene _{eg. No} 2 () () 4	31772
	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		Vear	3. Time of Death
	Physici /Medic		OLIVE LINDEN	DAWLEY				09	26 2	004	21:55 p ^M
7	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County		
			Hartley Hall Nurs			Pocomoke			Worce	ster	
	Funeral Director		035-10-5582	F 7. Age (In	yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		913		lace (State or Foreign E Island
	and w	}	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	f sho	5	MD								1 XYes 2 □ No
	28a-	Director	MD Worceste 10e. Street and Number	EL P	ocomoke (10f. Zip Code		1	0g. Citizen of V	/hat Cour	atry?
	ath with the Marylan 23a or 28a-f show	<u> </u>	1006 Market Stree	a t		21851			US		, .
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi	ispanic Origin? (Specify Yes or No-			an Indian,
36	72 hours after death with the Maryland Insturel, or items 23a or 28a-f show Jical Exacilinet sust burtuillind at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2 2 5No	n, Mexican, Pue Specify:	rto Rican, etc.)		k, White, whit	
ğ	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/Inc	dustry
215	hin 7.	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w)	orking			,
7	d wit	Completed	12	1	Home	maker		I	Domesti	С	
g	a Hy othy	Be (17. Father's Name (First, Middle, Last					ame (First, Middle, A	Aaiden Sumam	ө)	
<u>a</u>	utd b Menta rrked rrked	ပ္	Thomas Murphy				Anna L	inden			
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Exacilitation once.		Janet Phillips (c	• • • • • • • • • • • • • • • • • • • •	19b. Maili	ng Address (Street a	and Number or F t, Ocean	Rural Route Number, n Pines, l	City or Town, MD 2181	State, Zip 1	Code)
Baltimore,	of He of He item	ĺ	20a. Method of Disposition		Ob. Place of Dispo	sition (Name of matory or other place	e)	Date 2	20c. Location -	City or To	wn, State
Ĕ	Page nent nnt: if ury o		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		Highland			0/2004	Johnsto	n, R	Γ
aĦ	permit. Departn Imports any inju		21. Signature of Functal Service Licer	· · · · · · · · · · · · · · · · · · ·		Name and Address		uneral Hor			
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Ë	ling Afte une	lon	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work		28d. Describe hov	w injury occurre	d	
Division of Vital Records,	or Atter fter dea Director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, str		∕es 2 □No	28f. Location (Str. City or Town,	eet and Numbe State)	r or Rural	Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exa and manner stated.	/ knowledge, death mination and/or in	n occurred at the tim- vestigation, in my op	e, date and plac inion, death occ	e, and due to the caurred at the time, da	use(s) and mar te and place, a	ner as stand due to	ated. the cause(s)
	o the ithin o the	Me	29b. Signature and title of certified	Trialmer stated.		29c. License	number	29	d. Date signed	(Month I	Pav. Yearl
)	F 3 F 8		100	104		1 _	4422		9 - 3		
			20 N	nomelated	(1)					7	3 T
2	70		30. Name and address of person who	cet st.	, 100	omsk	e, N	1D 21	851		
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	32. Segistrar's S	signature A	rester					

			1 - For Stata Registrar	State of	Maryland	-	artment of rtificate o			•	giene Reg. No.	0 4	317	73
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of De Month	ath Day	Year	3. Time o	if Death
	/Medic		John Abel Dunba:							Septemb			5:43	рм
	Examir	ner	4a. Facility Name (If not institution, give		-		4b. City, Towr					inty of Death		
			412 Silver Spri 5. Social Security Number 6.5		le 7. Age (In yrs. las	t hirthday)	If Under 1 Ye	r Spri	ng r 24 Hrs.	8. Date of Bir		ntgome		
	Funeral Director			1 ½ M 2□ F	59	Yrs.	Months Day			(Month Da Aug. 6,	y 1945	Wash	place (State ntry) Lngton	or Foreign DC
ō			Usual Residence of Decedent					1						
arylar	ahow	-	10a. State 10b. County		10c. City, 7								10d. Inside C	•
he M	Ba-f	ecto	Maryland Montgo	mery	Sil	lver	Spring							2% No
death with the Maryland	Len Len	- E	10e. Street and Number	_			10f. Zip Cod				_	of What Cou	ntry?	
eath	18 23 Liusi	erai	412 Silver Spri		e dent Ever in U.S.	13	20910 Was Decedent		rigin? (Sno	noity Von as No		USA Race - Ameri	one Indian	
fter d	r Itan	Funeral Director	1 □ Never Married 2 □ Married	Armed Ford	ces?	15.	If Yes, specify C	uban, Mexica	in, Puerto	Rican, etc.)		Black, White,	etc.	
Sours a	le m	by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Da	tes:Vietna	m	1⊡Yes 2⊠in	lo Specify	<i>'</i> :		Spe	ecify: Whi	te	
72 h	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	1	(Give	dent's Usual Oc kind of work do	ne durina mo:	st of worki	na	16b. Kind o	of Business/Ir	dustry	
Mithin A	han M	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use rei	ired)			Cons	tructi	on &	
Elled A	Hygie thar I int, II		17. Father's Name (First, Middle, Last	2		Cor	ıstructi		er's Name	(First, Middle,		ractin	g	
yiand 21213-0030 ould be filed within 72 hours after	kad o	To Be	John A. Dunbar,	•						zabeth		,		
should	mari umat	-	19a. Informant's Name/Relationship	Type, Print)	7	19b. Mailir	ng Address (Stre	et and Numb	er or Rura	I Route Numbe	er, City or To	wn, State, Zij	Code)	
and 2 sl	aith a 127 is er tra		Bernadette Willia	amson/Da	ughter	4302	2 Federa	al Stre	eet,	Rockvil	le, M	2085	3	
es 1 s	of He fitan foth	13	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Dommuni from C	com	e of Dispo	sition (Name of natory or other p			er 27,		on - City or To		
mit. Pages	ant:		`4 □Donation 5 □Other (Speci		FOI	rt Li	ncoln rv		200		Brentw	ood, N	Marylan	nd
permit.	Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than *natural; or Itams 23e or 28e-1 ahow any injury or other traumatic evant, if a Mudic. Exaciliter cust be notified at once.		21. Signature of Fineral Service Lice	A Co	le	F 5	2. Name and Adrancis Do Unive	ress of Facil Col. ersity	lins Blvd	Funeral	Home	Inc.	, MD 2	.0901
di			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ine ons that ca	used the death.	Do not ent	er the mode of o	tying, such as	s cardiac o	r respiratory ar	rest,		Approximation interval Bet	(e tween
Ph	ysician		Immediate Cause (Final disease or condition	Sud	Den	Card	iza de	esta					Onset and	
	Medical aminer		resulting in death)	Due to (c	or as a consequen	,	0	1-1						
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ted	nsit	Examiner	Sequentially list conditions, fary, leading to in mediate cause. Enter Underlying Cause (Disease or injury	Caro		v 5	. dis	<) = &						
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cate be executed	physician and s the burial-transit	dicai		d										
rifica	as th	Jedi	IE ECMAI C											
The faw requires that the death certifi	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Fetal de		JEctopic pregna	ncy			23d.	Date of delive		
	the a	/sici	1 Yes 2 No	4□Pregna 9□Unknov	int at time of deatl	h 5□	Dther (specify)	_				Month	Day '	Year
that th	ad by detac		Part II. Other significant conditions	contributing to de:	ath but not resulting	ng in the u	nderlying cause	owen in Part	1	23a Did to	phacco use c	ontribute to t	no cause of s	loath?
w requires i	sign Id be	d by				9	noonying occase	g.voi ii i ait.				3 ☐ Prot		
5 ≥ 8	peershou	ete								24a. Was	20 24	b. Were auto	anu findinas	
he ta	e has age 2	Completed								autop perfor	rmed?	prior to co death?	mpletion of c	ause of
VILAI Icien: T	tor, p	0	25. Was case referred to medical			 		26 Place	e of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 No	
(0)	direc	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🗆 In	patient 2□ER	/Outpatien	t 3 DOA	Othor		ne 5 X Resid		Other (Specif	v)	
	fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month	Injury 28 , <i>Day</i> Yea <i>r</i>)	lb. Time of Injury	28c. In			28d. Describe h			.,	
Attending	death. c tor : A / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				M 1	Yes 2						
or A	Dirac Dirac in by	Certification:	4 Homicide determined	286. Place C	of Injury - At home g, etc. (Specify)	e, farm, str	eet, factory, offic	e	2	28f. Location (S City or Tow	Street and Nu m, State)	mber or Rura	il Route Num	ber,
L letiqs	ours and filled		29a. Certifier 1 Certifying Pl	nysician: To the b	est of my knowle	dge death	occurred at the	time date ar	nd place a	and due to the	Causo(s) and	mannor an a	lated	
To the Hospitel or Attending	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Example)	miner: On the bas	sis of examination	and/or in	estigation, in m	y opinion, dea	ath occurre	ed at the time, o	date and place	ce, and due to	the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier)			29c. Lice	nse number		- 2	29d. Date sig	ned (Month,	Day, Year)	
1	Ò		104	60)		D	17655	5		SEPT	۲. 22	, 200	4
1			30. Name and address of person who			_	,							
			LAURENCE P. K 31. Date filed (Month, Day, Year)	ELLY ME	gistrar's Signature	7901			FIT	AKOMA	PARK	(MD	20912	<u></u>
	Sta Registr		SEP 2 3 20		gistrar's Signature	19	Spark	2						

			1 - For State Registrar	State of	Maryland /		tment of F	lealth and M Death		giene		3:774
	Blood		1. Decedent's Name (First, Middle	a, Last)					2. Date of Da Month	ath Day	Voor	3. Time of Death
	Physici /Medio		Avvamma	Enjat	i	Eswa	arrao		Sept		Year 104	8:10 am
	Examin		4a. Facility Name (If not institution	, give street and numb	oer)			Location of Death		4c. Count		
			Suburban H				Bethe					gomery
	Funeral		5. Social Security Number 216-64-6891	6. Sex 7.	Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 1 / 1 8 /	th y, Year)	9. Birthp	place (State or Foreign htry) Idia
	Director		Usual Residence of Decedent		86	115.			1/18/	1918	In	dia
	land ow		10a. State 10b. County		10c. City, To	wn or Loca	ation				1	0d. Inside City Limits
	Mary f sh	tor	MD Monte	gomery	Roc	kvi]	lle					1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	*			10f. Zip Code			10g. Citizen of	What Cour	itry?
	h witi		6121 Montros	e Road			2085	2			USA	
	deat ms	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. W	as Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No	- 14. Rad	e - Americ	
9	or Ite	/Fu	1 ☐ Never Married 2 ☐ Marr		₩No		Tes, specify Cube		nican, etc.)	Specif	ck, White,	
21215-0036	ural',	d by	3 Widowed 4 □ Divorced									sian
7	"nat	Completed	15. Deceden (Specify only highe:	st grade completed)	168	a. Deceder (Give ki	nt's Usual Occup- nd of work done o	ation du <i>ring m</i> ost of work f)	ing	16b. Kind of B	usiness/Ind	dustry
2	withir ene. then	mc	Elementary/Secondary (0-12)	College (1-4	or 5+)			"		0	,	
g 7	filled Hygid ther		17. Father's Name (First, Middle,	Last)		HOI	nemaker	18. Mother's Nam	e (First, Middle.		hom	e
an	d be ental ked c	To Be	unk. Made	dirala					ca Yal		,	
Maryland	shound M	-	19a. Informant's Name/Relations	hip (Type, Print)	19	b. Mailing	Address (Street a	and Number or Rur	al Route Numbe	ar, City or Town,	State, Zip	Code)
	alth a		Gloria Dixit	/Daughter								,Md20852
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	II	20b. Place	of Disposit	ion (Name of tory or other plac	e)	Date	20c. Location	City or To	wn, State
<u>E</u>	Page Int. I		1 Surial 2 □ Cremation '4 □ Donation 5 □ Other (S		210			on 9/23	3/04	Adelph	ni Ma	aryland
<u>a</u>	ppartr ponte y inju		21. Signature Judaral Service	Ligenses								
<u> </u>	89789		Mulitary	tell "		92	41 Col	umbia B	lvd.Si	lver S	prin	E,P.A. g.Md20910
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death. Do	not enter	the mode of dyin-	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition								4	Onset and Death
2	/Medical		resulting in death)	Due to (or	as a consequence	e of):	11011	1.1/2 11	71			
104 2810AM	Examiner		Sequentially list conditions.	b	ASPIRA	770/	V P	ATREM	VIA			
100	ogit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to for	as a collecquelica	o vi).						
20	and -trans	каш	that initiated events resulting in death) Last	c. Due to /or	as a consequence	n of \:						
21/0 8760,	ate be executed thysician and the burial-transit	al E		Due 10 (01	as a consequence	5 01).						
12/		dical		d								
9×6	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy					224 Da	مراماه المراد	
Bo	atter after I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n 2 Fetel death t at time of death		ctopic pregnancy Other (specify)				te of delive nth	Day Year
o.	that the de ed by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow								
5 9	requires that the death certific een signed by the attending p hould be detached for use as	by PI	Part II. Other significant condition	ns contributing to deat	h but not resulting	in the und	erlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
URREM. Records,	quire n sig uld b	q pe							1 □ Y	es 2 No	3 🗌 Proba	ably 4 Unknown
2 3	s been s	ompleted							24a. Was a		Were autop	osy findings available
	The law ate has b page 2 si	E					-		autop: perfor	med2	death?	No
JSG. Vital		3e C	25. Was case referred to medical		7			26. Place of Deatl		1	1000	20140
	dii S	To B	examiner? 1 ☐ Yes 2 No	Hospital: Inp	atient 2 ER/O	utpatient	3 DOA Othe		me 5 Resid		er (Specify)
n of			27. Marmer of Death 1 Natural 5 ☐ Pendin	28a. Date of I (Month,	njury 28b. Day Year)	Time of Injury	28 c. Injury Work	at ?	28d. Describe h	ow injury occurr	ed	
# Sio	death. ctor: A y the fu	cati	2 Accident investig	pation			M 101	res 2 □No				
IMMA Division	i or Attendation after deati	Certification:	3'☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place of building,	Injury - At home, f etc. (Specify)	larm, stree	t, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
#	spitel		200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
AUVAMMA Divisi	Hosi 24 ho Fund Hely f	edical	29a. Certifier Certifyin (Check only one) Medical	g Physician: To the be Examiner: On the basi	s of examination a	ge, death o .nd/or inves	ccurred at the tim stigation, in my op	e, date and place, sinion, death occurr	and due to the c ed at the time, o	ause(s) and ma late and place, a	nner as sta and due to	the cause(s)
A	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Med	29b. Signature and title of certifier	and manner	sialeu.		29c. License	number	1 9	29d. Date signed	1 (Month. f	Day, Year)
	- \$ - 0) Id	2000	On . 10	' A	_	-2766		9/2	100	, ,
	ν		30. Name and address of person	who completed cause	of death (Item 23a)			2100		1/00	1 7	
			Alpana Goswa	1 //			-	#G100	Pooles-	11- 11	3 222	
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	E VIII	P		KOCKV1	тте,мо	1_208	152
	Registr	ar	SEP 23	2004	was /	0	Sparks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 17, Year 2004 **Physician** ARTHUR FINGERHUT 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HWBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG 18, 1912 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 ☐ F · Yrs. WASHINGTON, DC Director 578-01-5145 92 Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Items 23a 1801 E. JEFFERSON STREET, #105 20852 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Heatih and Mental Hygiane. Item 27 is marked other than "naturel", or Iter 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 SELF EMPLOYED RETAILER LIQUOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EDWARD** FINGERHUT BESSIE SIEGAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EARLE FINGERHUT, 9 COLEBROOK COURT, POTOMAC, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Dapartment of He
Important: If iter
any injury oth 1 X Burial 2 □ Cremation 3 X Removal from State `4 □ Donation 5 □ Other (Specify) KI KING DAVID MEMORIAL GDN. 9/20/2004 FALLS CHURCH, VA. 21. Signa are of uneral Service Licens 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the daath certificate be executed burial-transit that initiated events tha attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by brillation 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A M 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To me best of my knowledge, death occurred at the little, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completaly (Check only one) 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) W

2

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ROCKVILLE,

Darker

MARYLAND

Name and address of pers who completed cause of death (Item 23a) (Type, Print)
 KRIS KUHN, M.D., 6121 MONTROSE ROAD,

2004

32. Registrar's Signature

31. Date filed (Month, Day, Year)

22

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Anne T. Filippone 19,2004 2:30 /Medical September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda
If Under 1 Year If Under 24 Hrs. Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🖾 F Yrs. Director 121-10-1247 June 11,1918 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 le marked other than "neturel", or items 23e or 28a-1 show : it item 27 te marked other than "neturel", or items 23e or 28a-f show or other treumatic event, the Medical Execution inval by notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery <u>Silver Spring</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 2623 Cory Terrace 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 1 Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) P Cataldo Ferraro Carmela Gambo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita A. Clarke Daughter 2623 Cory Terrace Silver Spring, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Injury. 1 4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia 09/21/04 Crematory 09
22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Silver Spring, MD mer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year) 06/302 \$ September 20, 2004 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Rockville, MD Atul Rohatgi, 9901 Medical Center Drive M.D. 20850 31. Date filed (Month, Day, Year) 32. Begistrar's Signature 22 oaks 2004 Registrar

30 Pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3/ Time of Death / Day Year **Physician** ROSALIND FISHKIN SEPTEMBER 18, /Medical 2004 4:50P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 82 Director 191-16-2645 APRIL 29, 1922 POLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tiem 27 is marked other than "natural", or tiema 23a or 28a-f show other traumatic event, the Modical Extending at MONTGOMERY MARYLAND SILVER SPRING Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15220 TOTTENHAM TERRACE 20906 UNITED STATES OF AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural". or Health injury of other transmitter. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: WHITE Completed by Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY CLINICAL LAB 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MEYER SOSLOWITZ IDA LIFSHITZ 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GAIL BRODSKY - DAUGHTER 316 PRETTYMAN DR. #6101, ROCKVILLE, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Donation 5 □ Other (Specify) SHALOM MEMORIAL PARK 09/20/04 PHILADELPHIA, PA 21. Signature of Funeral Service Licenses ENAR SACCE FOR THE TOP TO SECTION OF THE SECTION OF Mel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

22

2004

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bush I. Ferdman MD, 3305 N. Ceizure World B) vd. Si ver Spri

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

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	Disconical		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dear			3. Time of	Death
	Physici /Medi		BENJAMIN	F	ORMAN					S		$2R^{2}$	20, 2004	9:00	P^{M}
	Examir	ier	4a. Facility Name (If not institution, give		er)		4b. City,	Town, or	Location o	of Death		4c.	County of Death		
			11905 GREENLEAF AV		A== (l=	In a biat at a		OMAC		04 Uro			NTGOMERY		
	Funeral Director		5. Social Security Number 6. Se 076-12-3629	X M 2□F	Age (in yrs. 8:	. last birthday) Yrs.	Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day, 19/26/19	Year)	Coun		r Foreign
			Usual Residence of Decedent								19/20/15	721	NEW Y	UKK	
	show		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						1	0d. Inside Ci	
	Ba-f s	Director	MARYLAND MONTGOME	RY	POT	ГОМАС								1 🕅 Yes	2 🗌 No
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10	fter d	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Force	s?		f Yes, spec	ify Cubar	, Mexican	, Puerto R	ify Yes or No- ican, etc.)		 Race - Americ Black, White, 		
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121	vithin ne. han	ig I	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	e retired)	go						
7	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	5+		ATTOR	NEY		10 Matha	de Nome		LAW			
anc	d be a	o Be	JACOB	FORMAN							(First, Middle, I				
Maryland	shoul nd Me mark	၉	19a. Informant's Name/Relationship (T			19b. Mailir	ng Address		MINNI nd Numbe		Route Number		S IMON r Town, State, Zip	Code)	
×	alth a alth a 27 ls		SANDRA N. FORMAN/V	VIFE							OTOMAC,				
ore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	D		Place of Dispo	sition (Nam	e of		Da			cation - City or To	wn, State	
<u>Ĕ</u>	Pag ment ant: I		'4 □ Donation 5 □ Other (Specify		1	DEAN MI	EM. GA	ARDEN	IS 0	9/22/	2004	OLNI	EY, MARYL	AND	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event. It a Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	udeur	2	ED 10	Name and WARD 91 KO	Address SAGE CKVI	of Facility L FUN LLE P	YERAL IKE,	DIRECT	ION	, INC.	2	
90	300		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that rais	ed the deat	th. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arre	est,	Á	Approximate Interval Betw	yeen
	Physician		Immediate Cause (Final disease or condition	ARTERIO									10	Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or a	as a consec	quence of):									
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89	ntifica ng ph	Med	IF FEMALE:	Poolinin				7							
Вох	ath ce ttendi or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth	2 Feta	al death 3[Ectopic pre					2	23d. Date of deliver	,	
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00	iw requir s been s should	lete									24a. Was ar		24b. Were autop	sy findings a	vallable
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sio	r Attending er death. ractor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2□N						
Division	spital or Al ours after d ieral Dirac filled in by	Certification;	4 Homicide determined	28e. Place of I building,	njury - At h etc. (Specil	ome, farm, stre fy)	eet, factory,	office		28	f. Location (Str City or Town,	eet and State)	d Number or Rural	Route Numb	er,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the besiner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred a estigation,	t the time in my opi	, date and nion, death	i place, and	d due to the ca at the time, da	use(s) te and	and manner as sta place, and due to	ited. the cause(s)	
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) you	~	S. (1	Ovne)	r	1523	6		S	ЕРТІ	EMBER 21,	2004	
	0		30. Name and address of person who co				Print)							2004	
			CARL MARGOLIS, M.D				PIKE :	#211	, ROC	KVILI	LE, MAR	YLAI	ND 20852		
	Sta <a registration<="" td=""><td></td><td>31. Date filed (Month, Day, Year) SEP 2 3 200</td><td></td><td>strar's Signa</td><td>g</td><td>Spor</td><td>Kal</td><td>,</td><td></td><td></td><td></td><td></td><td></td><td></td>		31. Date filed (Month, Day, Year) SEP 2 3 200		strar's Signa	g	Spor	Kal	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND TTEM #29d PER PHY C836 975 Frate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Theodore Roosevelt GOOD 33 2000 1521) eptember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 1 M 2 ☐ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct.14,1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 228-10-2493 Yrs. Director 85 Virginia Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumstic event, the Medical Exeminer must be multified at 1 XYes 2 No Washington Hagerstown Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 357 Radcliffe Avenue 21740 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ■ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify: Completed by **3**Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. custodian school 11 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I Pages 1 and 2 should be Jennie R. Aleshire Noah W. Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9900 Sharpsburg Pike, Hagerstown, Md. 21740 Judith Hartle - daughter If itam 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State ō Rose Hill Cemetery 9/27/04 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forteral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME once 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athenoscithosi c **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, physician Physiclan/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has be irector, page 2 s 1□ Yes Division of Vital 2 No the Hospital or Attending Physician: Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral (28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Atter Natural 5 Pending Injury death. 1 Yes 2 No investigation thours atter death.

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ely tilled in by the ti 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) To within 24 hours ...
To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature of cer D56783 mpleted cause of death (Item 23a) (Type, Print) 30. Name Hagerstown Maryland Campus Rd 11110 Modical

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Mo

Day, Year

2004

SEP 27

2. Registrar's Signature

			1 - For State Ragistrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I rtificate of			giene	31780		
H	Physici		1. Decedent's Name (First, Middle, Last, Anne Marie Gary					2. Date of Dea Month Sept. 2	Day Yeer 2004	3. Time of Death 3:45 P M		
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County of Deat			
	1	Н	10210 Battleridge Place Montgomery Village Montgomer									
L	Funeral Director		5. Social Security Number 6. Sec. 218-80-0530	x	e (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 10	y, Year) 9. Bird Co 1941 Mary	nplace (State or Foreign untry) yland		
	the Maryland r 28a-f show	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10c. City 10c. Ci									
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9036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show safeal Examirer must be multiled at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2X1 If Yes, Give Year or Dates:	No.	Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Consider			
21215-0036	_	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occup kind of work done DO NOT use retire atic Ins	during most of word)	king	16b. Kind of Business/I YMCA	6b. Kind of Business/Industry YMCA		
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury ocother traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	All Soul	matory or other pla s Cemeter	y 2	004	20c. Location - City or 1 Germantown,			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	3.76	P 25	2. Name and Addre 10 Ga	ess of Facility De' Dest Dec Lithersbu	Vol Fune er Park rg, MD	ral Home Drive 20877			
	Physician /Medical Examiner		23a, Fayt. Enter the disease, or complessor, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Metasta	the death. Do not enter. tic Gallbl a consequence of):			or respiratory an	rest,	Approximate Interval Between Onset and Death		
8760,		Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as	a consequence of):							
.O. Box 6	death certifical e attending phi d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnance	y		23d. Date of dein Month	rery Day Year		
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	nderlying cause giv	ren in Part I.		bacco use contribute to es 2∑No 3 ☐ Pro			
Vital Record	The law ate has b page 2 si	Completed						24a. Was a autop: perfor	sy prior to co	opsy findings available ompletion of cause of		
Zi.	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital:	at 200 EB/Outration	ot 30 DOA Oth		th Check on or				
ion of	ling After Tunes	-	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2 ☐ EP/Outpatier y Year) 28b. Time o Injury	28c. Injur	4 Indiang n		ence 6 Other (Speci ow injury occurred	fy)		
Division	al or Attendi s after death. Il Director: A id in by the fu	Sertification:	3 Suicide 6 Could not be determined	28e. Place of Injubulg	ıry · At home, farm, str :. (Specify)	eet, factory, office		28f. Location (S City or Town	treet and Number or Rur n, State)	al Route Number,		
	the Hospital or and 24 hours after the Funeral Direct holes of the funeral Direct holes of the filled in the following the filled in the following the filled in the following filled in the filled in the following filled in	edical C	29a. Certifier (Check only one) 2 Madical Examin	sician: To the best of nar: On the basis of and manner sta	examination and/or in	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manner as s ate and place, and due t	stated. to the cause(s)		
	To the P within 24 To the F complete	Ň	29b. Signature and title of certifler	1		29c. Licens	e number	2	9d. Date signed (Month,	Day, Year)		
•	6		6/7/	/		MD 33	3109	S	Sept. 21, 20	004		
			Jimmy wang, M.v.				gton, D.C	. 20007-	-2197			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 22 200	32. Registra	r's Signature	Sporks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death September 21, 2004 Physician Teresinha Pires Gouveia 2:30 аМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing & Rehab. Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Brazil **Funeral** Months 1 ☐ M 2 🔀 F 77 Director 577-64-9794 Usual Residence of Decedent death with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23a or 28a-f short the Medical Examinat must be notified at Director 1 ☐ Yes 2 K No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8417 Flower Avenue 20912 Brazil Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: White 1XIYes 2□No Specify: Brazilian Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F pe mit. Pages 1 and 2 should be partment of Health and Mental portent: If Item 27 is marked y injury or other treumatic even. Alcebiades Fernandes Silva Dulce Pires Carvalho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Weldeck A. Gouveia/ Husband 8417 Flower Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of 20a. Method of Disposition September 24 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan 1 ☐ Burial 2 TCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Crematory Alexandria, Virginia permit. Departn Importe 21. Signature of Funeral Service Licenses 22. Name and Address of Facil Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9☐Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 1 Yes 2 No Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☑No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After or Attending 1 Matural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel [Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

DHMH 17 Rev 1/2001

1111

30. Name and address of person who pompleted cause of death (Item 23a) (Type, Print)

2004

MD

32. Registrar's Signature

Paper

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22

Yeheyis

31. Date filed (Month, Day, Year)

SEP

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Docks

9/21/2004

SPRING ST. # 214, SILVER SPRING, MD 20910

			1 - For State Registrar	State of N	Maryland		artment o			and Me		giene	104	317	02
			1. Decedent's Name (First, Middle, Last)	7.00							2. Date of Dea	ath		3. Time o	f Death
	Physicia		Rita A. Gibbons								Month	S I	Year O4	1315	- + M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and numbe	or) , ,	. (4b. City, Tow	m, or L	ocation o	of Death		4c. C	ounty of Dea	ith	· · ·
			PENINSULA REGION	M MU	AICK!	COUTA	,	110	1560	114			NICO	mics	
	Funeral		Social Security Number 6. Sex		Age (In yrs. la:	* * * * * * * * * * * * * * * * * * * *	If Under 1 Y		If Under	24 Hrs.	8. Date of Birt	h v Year)	9. Bi	rthplace (State	o <i>r Foreign</i>
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	D		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside C	iby Limits
	sho	ក	Florida Lee												2 X No
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	hours after death with the Maryland tural', or Itema 23a or 28a-f show at Examinar must be nutitied at			Month										ountry :	
	na 23	Funeral	201 Lake Avenue,	2. Was Deceder	nt Ever in U.S	. 13. \	339 Was Decedent		panic Orio	gin? (Spec	ifv Yes or No		.S.A . Race - Am	erican Indian,	
10	r Iter	핊	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2 ☐			f Yes, specify (Cuban,	Mexican	, Puèrto R	lican, etc.)	1	Black, Wh	ite, etc.	
93	urs a	ρ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		I□Yes 21€	No	Specify:			S	pecify: Wh	ite	
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21	filed withi Hygiene. Ather than	Co	12			Hom	emaker					<u>Own</u>		<u> </u>	
pu	d fall	Be	17. Father's Name (First, Middle, Last)					1.			(First, Middle,	Maiden S	umame)		
<u>y</u>	should be and Mental s marked o umatic eve	၉	Oswald A. Dubovy							len L					
Maryland			19a. Informant's Name/Relationship (Ty)				g Address (St					-			
	is 1 and 2 of Health Item 27		Thomas D. Gibbons 20a. Method of Disposition	/ Son	20b Pla		Wild F		er Co	ourt,				55 r Town, State	*
Baltimore,	0 0 == ==		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta	cer	netery, cren	natory or other Heaven	place)	S	eptemb	er 25,	200. 200	tion - City o	TOWN, State	
莊	permit, Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Ce	emeter		el el	of Facility	200	4	Silve	r Spri	ng, Mar	yland
Ba	permit. Departr Importuany Injugence.		21. Signature of Furieral Service License	0)	Fr	Name and A	J. C	Colli	ins F	uneral	Home	Inc.		
			23a. Part Enter the disease, or compl	cations that caus	sed the death								Sprin	g, MD 2 Approxima	
			shock, or heart failure. List only on Immediate Causa (Final	e cause on each	line.				0401140	0414140	Toophiatory at	1000		Interval Be Onset and	tween
	Physician /Medical		disease or condition resulting in death)	MULT			FAIL	124						1 DAY	
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oʻ	exec an an rial-tr	Еха	resulting in death) Last	,	as a conseque	. ,								(
8760	ate be chysicie the bu	dical		CORON	worky 1	Trek	Y DIS	4-56						KENE	>
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burtal-transit	Med	IF FEMALE:												
Вох	leath certific attending p	an/h	23b. Was decedent pregnant	3c. If yes, outcon 1 ☐ Live birth	ne of pregnand		Ectopic prean	ancv				23	d. Date of de	,	
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on	ding F th. : After : funera	tior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, I	Day Year)	Injury		Work?	s 2 🗆 !			, , ,			
Division	l or Attendil after death. Director: A	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At hom	ne, farm, str	eet, factory, of	fice		28	Bf. Location (S	Street and	Number or F	ural Route Nur	nber,
Ö	al or A s after if Direct od in by	Certification;	4 Homicide determined	building,	etc. (Specify)						City or Tox	m, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	ician: To the be	st of my know	ledge, death	occurred at th	ne time,	, date an	d place, ar	nd due to the	cause(s) a	nd manner a	s stated.	
	he H in 24 he F plete	Medical	one)	and manner	stated.	on and/or in	vestigation, in i	ny opin	nion, deal	tn occurred	at the time,	date and p	lace, and du	e to the cause(s)
	With To t	Σ	29b. Signature and tille of bentfier				29c. Lie	cense r	number	- 1			-	th, Day, Year)	
			1				1	253	53			9-	21-0	2004	
	10		30. Name and address of person who co		of death (Item :	23a) (Type,	Print)	(18 6	un	M	7				
	sta Regist		31. Date filed (Month, Day, Year) SEP 23 200	1	strar's Signatu	ire &	Print)	1/2	,						

DOD 9/21/04 130

Gibbons, Rita 2084/05/18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lorraine Hartshorn September 25, 2004 10:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital eonardtown Mary's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2/7 F 80 Yrs Director 219-16-2538 June 18,1924 Washington,DC Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Modical Examiltar must be motified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37720 Apache Road 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2 ☐ No Yes, Give A 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed w h and Mental Hygier 7 ia marked other th Accountant Aircraft Simulation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Juanita Horsman ೨ Otis Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ent: If item 27 la Norma Webber/Daughter other t 37720 Apache Road, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Importent: If any injury or once. `4 Donation 5 Dother (Specify) Mt. Zion Cemetery October2,2004 Mt. Zion, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, uchne torderer Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WWOSEPSIS **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause, Olisease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ llapse 2√Z No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page this certificate 1 ☐ Yes 2 No 2 No 1 Yes Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D60888 09

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

DHMH 17 Rev 1/2001

Shanti Building,

ess of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan,

SEP 2 8 2004

31. Date filed (Month, Day, Year)

Solomons, Maryland 20688

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 70 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Jesse Hemphill 09 5:28 a.M 21-2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**X** M 2□ F Director 08-27-1923 250-12-9797 RockHill, Usual Residence of Decedent with the Maryland 10a. State r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland 1X Yes 2 □ No Prince Georges Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6520 Seat Pleasant Drive 20743 Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene.
sair: If item 27 is marked other than "natural", or Itema 23, and or other traumatic event, the Medical Exeminer must U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1943-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: Black 3 Widowed 4 Divorced Year or Dates: 1945 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Mailhandle Trackman Amtrax 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Hemphill Annie Belle Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 Seat Pleasant Drive Seat Pleasant, Maryland, 20743 Jennie M. Hemphill/Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Cheltanham Veterans
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 09-29-04 Cheltanham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. Bacon CCD36/ 3447 14th St., N.W. Wash., D.C. 20010 Wanda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner ASPIRATION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Olie to for as a oxisequence of The law requires that the death certificate be executed burial-transit SHOCK Due to (or as a consequence of): P.O. Box 68760, REWAL DISGAGE END STAGE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery łoż 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, director, page 2 should be 1 Yes 2 No 3 Probably 4 Nunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2**X** No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' ٩ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ihis Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. efter death 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospital within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D-17874 nivo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 38 NE MD 3717 BRENTWOOD S. M. NAYAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2004 Registrar

	-		1 - For State Registrar	3		Department of Certificate of		F	leg. No. ()	4 3	785
	Fhysic /Medi		Decedent's Name (First, Middle, MARY MAGDEL	INE HUNSU	ICKER			2. Date of Dea Month	Day	Yeer 3. Tir	me of Death
1	Exami	er	4a. Facility Name (If not institution,	give street and number)	nach	4b. City, Town	n, or Location of Dea	th	4c. County	, ,	
	Funeral		5. Social Security Number	5. Sex 7. Age	e (In yrs. last birt	hday) If Under 1 Ye	ar If Under 24 Hrs	8 Date of Birth		PONICO	tato or Foreign
	Director		214-70-7121 Usual Residence of Decedent	1 □ M 2 🖫 F		Yrs. Months Day	ys Hours Min		Year) 1923	9. Birthplace (Si Country) Kentu	cky
	nyland show	_	10a. State 10b. County		10c. City, Town					10d. Insi	de City Limits
	he Ma	Director	MD Wicomi	СО	Pittsv						Yes 2 XNo
	with t	i Dir	10e. Street and Number 34461 Rounds Rd			10f. Zip Code		1	log. Citizen of V	What Country?	
	ter death	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S.		350 of Hispanic Origin? (5	Specify Yes or No-	US 14. Bac	e - American India	an .
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, tiem 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, the Medical Eventualizations	þ	1 ☐ Never Married 2 ☐ Marrie 3 ※ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:	No	If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No <i>Specify:</i>	to Rican, etc.)	Blac	ck, White, etc. White	,
5-0	72 hc natur	Completed	15. Decedent's (Specify only highest		16a.	Decedent's Usual Occ	cupation ne during most of wo	rkina	16b. Kind of Bu	usiness/Industry	
2121	within ene. than "	idmo	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work dol life. DO NOT use ret	ired)	1	0 11		
d 2	filed Hygid Sther Snt, I	ပိ	17. Father's Name (First, Middle, La	ust)	П	omemaker	18. Mother's Na	me (First, Middle, I	Own Ho		
Maryland	Jental Jental Jental Jicev	To Be	William Hogg					a Bogg		,-,	
lary	2 shorand halls ma		19a. Informant's Name/Relationshi	(Type, Print)	19b.	Mailing Address (Stre			, City or Town,	State, Zip Code)	
	l and lealth m 27 her tr		Rusty S. Huns	ucker	3/	4461 Round	ds Rd., P				
סר	If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		cemeter	Disposition (Name of v, crematory or other p	9-28	-04	20c. Location -	City or Town, Stat	(0
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to once.	1	* 4 □ Donation 5 □ Other (Special Signature) of Fundal Service Li		Trinit	ty Garden	of Memor	v i	Newark	, Maryla	nd
Ba	permit. Departr Importe any inju		> It Fiel!	Buchas		IOR Willia	m St., B	he Burba arlin Ma	ige Fur	neral Hor	ne
8760,	The law requires that the death certificate be executed A part of the attending physician and stage 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part. Enter the disease or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Prey D Due to (or as a Due to (or as a	a consequence o	of by	did cas	<i>)</i> '		Interval Onset a	l Between and Death
9	ntificate ing phys s as the	Medi	IF FEMALE:								
.O. Box	that the death certifice ed by the attending pt detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 6 9 □ Unknown	2 Fetal death	3 □Ectopic pregnar 5 □ Other (specify)	ncy		23d. Date Mor	e of delivery nth Day	Year
rds, P.	v requires tha been signed I should be det	by	Part II. Other significant condition	contributing to death bu	it not resulting in	the underlying cause of	given in Part I.	23e. Did tob	I	ibute to the cause	
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				th (Check only one	*		
of	Phys this ral dii	on; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatier 28a. Date of Injury (Month, Day	y 28b. Ti	Satisfit SE DOA		ome 5 Resider			
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Ο̈́	n ir fe	Serti	4 Homicide determine	building, etc.	(Specify)	ii, stieet, factory, office	8	City or Town,	State)	ar or Rural Route N	iumber,
	To the Hospitel within 24 hours a To the Funerel Completely filled i	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and	death occurred at the for investigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and man te and place, a	nner as stated. nd due to the caus	se(s)
	To the within 2 To the complet		29b. Signature and title of certifier		1 -0	29c. Licer	nse number	29	d. Date signed	(Month, Day, Yea	r)
•				egm)	hus	1)	252/7	7 9.	-24-0	4	
~			30. Name and address of person wh	completed cause of de		^	4				
D	Sta	0	Charles Steamer 31. Date filed (Month, Day, Year)	32. Registrar	t . Venn	Rd, Princess	Anne, Ma	, 21853			
	Registr	re.	SEP 2 7	2004	-	break !					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 27 **Physician** 5:20 A M 2004 Pauline Geneva Hoover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clearview Nursing Home Hager Stown.

If Under 1 Year If Under 24 Hrs. S. Date of Birth (Month, Day, Year)

January 23, 1913 Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□м ЖХғ Yrs. 91 Maryland Director 220-54-4835 Usual Besidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at Director 1 Yes 2 No Williamsport Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21795 USA 18 N. Vermont St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wh Depertment of Heelth and Mantal Hygient Important: if Item 27 is marked other tha any findury or other traumatic event, Itel. 12 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Bessie Wolford Martin L. Ausherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry W. Hoover - Son 17115 Miner Ave. Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Dispurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State * 4 Donation 5 Other (Specify) Greenlawn Mem. Park Sept.29,2004 Williamsport, Maryland 21. Signature of Funeral Service OSDOPNE AFTITIEF BITY Home. P. A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 /Medical Due to (or as a consequence of): Examiner Anterio Scherotis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical ₽ \$ IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, mallister Richts respection 1 Yes 2 No 3 Probably 4 Haknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an chione obliticher autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 4No of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Hoursing Home 5 Residence 6 Other (Specify) 1 Yes 2 T Ner ۵ this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; Division 5 Pending 1 ANatural s efter death. Il Director: Affi Id In by the fur 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hoer.
within 24 hours effer
To the Funeral Dir 4 | Homicide 29a. Certifier 16 centrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -(But MD SEPT 27.2004 D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 MILLST MAGERSTOWN, MO 21740 VASAWT DATTA mo 31. Date filed (Month, Day, Year) SEP 2 8 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 27 2004 2:40 P M SEPTEMBER GARLAND HOLMES JR. **CLEVELAND** /Medical Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

OCT. 26, 19 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 119 E. Washington St., Apt. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Yrs. MARYLAND Director 218-50-3437 Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other treumatic event, the Medical Examples must be possibled at once. 1⊠Yes 2 No HAGERSTOWN MARYLAND WASHINGTON Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 119 EAST WASHINGTON STREET, APT. Funerai 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠Yes 2 □ No 1970If Yes, Give
Year or Dates: 1973 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LILLIAN VIRGINIA TOMS CLEVELAND GARLAND HOLMES SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 E. Washington St., Apt. 2, Hagerstown, MD 21740 PHYLLIS A. HOLMES/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY | 9/30/2004 | SMITHSBURG, MARYLAND * 4 □ Donation 5 □ Other (Speciff) 22. Name and Address of Facility 7606 Old National Pike 21. Signature of Fl Paul m. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lines. Approximate Interval Between Onset and Death Immediate Cause (Final hOSU **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of); Examiner 0 ho 20185 Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ a sonorow 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 1 ☐ Yes 2E No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 28d. Describe how injury occurred 27. Mann Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? eral Director: Atter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar DHMH 17 Rev 1/200

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

To the I

of a war shing

Registrar's Signature

Corece

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Mary		ertificate of			eg. No.	04 3	1788			
	ician dical	1. Decedent's Name (First, Middle, Last) Mildred Louise HO	RNBAKER				2. Dete of Dee Month Septembe	Dey	Year 2004	Time of Death			
	niner	4e Fecility Neme (If not institution, give si	treet and number)	4b. City, Town, or L									
		16903 Pickwick La	ne			Hagersto	own	Wa	shingto	n			
Funer Directo		213-24-8961	iex 7. Age (In yrs. last birthday) If Under 1 Y. Months Da			s Hours Min. (Month, L		Birth 9. Birthplace Country) 4 1928 Mary1		(State or Foreign and			
puel * =		Usuel Residence of Decedent 10a. Stete 10b. County	10c	. City, Town or I	ocation		10d. Inside City I						
Meny	ţ	Maryland Washingt	on	Насе	erstown				1	☐ Yes 2¶∏No			
h the	<u>i</u>	10e. Street end Number		nage	10f. Zip Code		1	0g. Citizen of \	What Country?				
th wit	a O	16903 Pickwick Lan	e		217	740		U.S.A.					
DEILITIOTE, MELYJEING ZIZIS-UUZU permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at	y Funeral Director	1 Never Married 2 Married	2. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	in U,S. 13	. Was Decedent of he if Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Rac	ce - American Ind ck, White, etc.	dian,			
ture!	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	163 Doc					Wh:	ite			
A I A I D-UUAU d within 72 hours eff giene. or than "nature!", or the Medical Exami	Be Completed	(Specify only highest grade		edent's Usuel Occup e kind of work done DO NOT use retire duction W			16b. Kind of Business/Industry Organ Parts Maker						
Hygin Hygin	ပိ	17. Fether's Neme (First, Middle, Last)	0	FIC	duction w	18. Mother's Nam				Kei			
Maryland od 2 should be file th and Mental Hy ?? is marked oth traumatic event	To B	Clarence Gladhill				Bessie	Mills						
Should be many		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mai	ling Address (Street	and Number or Rur	al Route Number	City or Town,	State, Zip Code))			
and 2 salth a n 27 is		William Hornbaker			903 Pickw		Hagers	town, M	laryland	21740			
Peges 1 nent of He nrt: If Iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Re	moval from State	 Place of Disp cemetery, cre 	osition (Name of ematory or other pla	ce)	Date	20c. Location -	City or Town, S	tate			
Dallimore, Semit. Peges 1 an Department of Heal mportant: if Item 2		4 ☐ Donetion 5 ☐ Other (Specify)	E		d Cemeter		7/27/04			1and			
permit. Departing	DUCE	21. Signature of Funeral Service Licensee	nnu		Name and Address E. Wil	ess of Facility $ ho$ lson $ ho$ l $ ho$ l.	linnich l Hagerst			21740			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death											
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Examine		resulting in death) Due to (or as a consequence of):											
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- F 9 W		resulting in death) Last Due to (or as a consequence of):											
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be de ched	ysic	Part II. Other significent conditions contri	ibuting to death but not	resulting in the	underlying cause giv	en in Part I.	23b. Did tol	bacco use cor	ntribute to the c	ause of death?			
that the post	된						1,2XY	s 2□No	3 Probably	4 Unknown			
requir	Completed by Physician/N						24a. Was ar perform		24b. Were eut available completic of death?	prior to on of cause			
	E O						1□ Ye	s 2 No	1 ☐ Yes	_			
	Be	25. Was case referred to medical examiner?				26. Place of Deetl	(Check only one	9)					
Physician: rthis cartifional diractor,	2	1 ☐ Yes 2 No	spitat: 1 🗆 Inpatient 2	□ ER/Outpatie		4 U Nursing Ho	me 5 Resider	nce 6 Othe	er (Specify)				
ing P	on:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor		28d. Describe ho	w injury occurr	ed				
or Attanding after death. Director: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st		Yes 2□No	28f. Location (Str. City or Town,		er or Rural Route	e Number,			
To the Mospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral	edical C	29a. Certifier (Check only one)	lan: To the best of my lan: On the basis of exam and manner stated.	mowledge, deel ination end/or in	h occurred at the tin	ne, date and plece, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as stated. and due to the ca	ause(s)			
To th To th	Me	29b. Signature and title of certifier	n		29c. Licens	e number	29	d. Date signed	Month, Day, Y	'ear)			
10		Hud Hou	udon	MI	DH	6473		09/2	4/04				
*3		30 Neme and address of person who com	pleted cause of deeth (I	tem 23a) (Type	Print)	PAIC	7 . 1	lador	star in	21740			
S	tate	31. Date filed (Month Day Year) 2004	2. Registrer's Signature	geture ope	K)			1200	P (0001)	1111			

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Marylan	d / Department <i>Certificate</i>		Mental Hygier	001 21/84
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, L THEODOG 4a. Fecility Name (If not institution, g UNIVERSITY OF	ive street and number)		own, or Location of Dea	Sept 18	Day Year 3. Time of Death 4c. County of Death NA
	Funeral Director		- 4	Sex 7. Age (In yrs. 1 1√2 M 2 □ F 81			S. 8. Date of Birth	9. Birthplace (State or Foreign
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event. The Medical Examinat must be notified at	Funeral Director	Maryland Prince 10e. Street and Number 9114 Wallace Roa 11. Marital Status	d 12. Was Decedent Ever in U. Armed Forces?	_ If Yes, specif		Ur	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Citizen of What Country? nited States 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	filed within 72 hours aft Hygiene. other than "natural", or ent, the Medical Exami	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12	INTes 2 No 194 If Yes, Give Year or Dates: — 194 Education rade completed) College (1-4or 5+)	6 1 Yes 2		orking	Specify: Black Kind of Business/Industry Private
Naryland	2 should be and Mental Is marked o	To Be (17. Father's Name (First, Middle, Las Charlie French 19a. Informant's Name/Relationship Vanessa Lee/Daug	Holmes (Type, Print)		Mamie Street and Number or F		v or Town, State, Zip Code)
Baltimore, N	Page nent o ant: If ary or		20a. Method of Disposition 1 Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other (Special Service Lice)	□Removal from State Har	lace of Disposition (Name emetery, crematory or oth mony Memori	o of er place) al Park 9/2	24/04 La	Location - City or Town, State
	Permit. Departrumborts tumborts Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List online disease or condition resulting in death)	mplications that caused the death one cause on each line.	Alexand 5538 Ma n. Do not enter the mode OEHEAR	er S. Pope rlboro Pike of dying, such as cardia		mes L1e, MD 20747 Approximate Interval Between Onset and Death
8760,	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):			
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pres			23d. Date of delivery Month Day Year
	w requires that been signed b should be dete	by	Part II. Dther significant conditions		ACCIO	ise given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Kunknown
of Vital Records,		se Completed	25. Was case referred to medical			26. Place of De	24a. Was an autopsy performed? 1 Yes 2 X Nath Check onl. one)	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of V	or Attending Physician: after death. Director: After this certifica in by the funeral director. I	atlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigative	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury M	04	Home 5 Residence 28d. Describe how inju	
Divi	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	al Certification;	3 Suicide 6 Could not determined	building, etc. (Specify)	Wedge, death occurred at	the time, date and place	City or Town, Star	s) and manner as stated
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Execution (Check only one)	miner: On the basis of examinati and manner stated.	ion and/or investigation, ir	n my opinion, death occ	urred at the time, date ar	ate signed (Month, Day, Year)
C	(3)		30. Name and address of pers n	OLUKEN	23a) (Type, Print)	15089 AJA4.	222 Sincre	ember 18 2004 ene Street
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2 4 200	3. Registrar's Signat	harts !			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. Month Day Year September 16, 2004 **Physician** 9:40 Jackson /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Prince George's Laurel | If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year, Nov. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 KF Months Days 65 Wash., DC Director 579-54-0596 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show 7 is marked other then "naturel" or Items 23a or 28e-f show treatmetic event, it a Medical Exemination was be notified at 1. Yes 2 No Directo Maryland Prince George's Laure1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8826 Hunting Lane #103 20708 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Privorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other then College (1-4or 5+) Elementary/Secondary (0-12) 12th Clerk Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health, and Mental Hy Importent: If Item 27 is marked oth any liury or other treumatic event 2008. Willie R. McDade Rose L. Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Lewis-Smith/Daughter #103, Laurel, MD 8826 Hunting Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 9/22/2004 Landover, MD `4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee (lua 4001 Benning Rd., N.E. Wash., DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediale Cause (Final disease Condition resulting in death) Metastatic Breast Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Months Metastatic Lung Cancer Sequentially list conditions, francisco and the cause. Enter Underlying Cause (Disease or injury that initiated events Due to [or as a consequence of]: Examiner Physicien: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical as the nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year detached for 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? ed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sign d be 1 Yes 2 No 3 Probably 4 X Unknown non insulin dependent diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an recurrent thromboembolish page 2 s has autopsy performed? 2 X No 1 Yes 2 No 1 Tes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7 1 ☐ Yes 2 💢 No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident after death the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel L the Hospitel completely filled tX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Dale signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier DOMES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Rd., #320, Laurel, MD Marie Dobyns, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) SEP 2 4 2004

SEP 24

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** John Paul Jones September 21, 2004 2:00P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Greensboro 12615 Ridgely Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 217-48-9520 Director October 22, 1948 Maryland 55 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or Items 23a or 28a-f show eny injury or other traumatic event, the Marical Exeminar recovers. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Director Greensboro Caroline Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21639 12515 Ridgely Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify 3 ☐Widowed 4 ☐ Divorced Caucasian 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Environmental Control 12 Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Virginia Boyles Lawrence Noble Jones ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2424 Fait Avenue, Baltimore, Maryland 21224 Son Eric Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9/26/2004 Denton, Maryland Denton Cemetery 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. Let only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, Due to for as a consequence offi-Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No. 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 certificate has autopsy performed? 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Maryes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Mont), Day, Year, 29b re and title of certifier 14 eted cause of death (Item 23a) (Type, Print) address of person Vensen, M.D., PO Box 690, Denten, Maryland 21629 Christian E. State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 24. 09 3:55 AM Wayne Kenneth Jones /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1704 Crestwood Circle
Social Security Number 6. Sex Salisbury
If Under 1 Year | If Under 24 Hrs. | Wicomico 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 ☐ F Months Days Hours Director 52 213-70-7885 January 11, 1952 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other than "naturel", or Items 23a or 28a-f shovent, it e Medical Examiner must be notified at 1 XYes 2 No Pocomoke City Maryland Worcester Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 Clarke Avenue 21851 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 XNo Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 X Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Public Works Department of Health and Mental Hy Important: If Item 27 is marked oth sny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Henry Jones, Sr. Mary Jane Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1704 Crestwood Circle, Salisbury, Maryland Bill Jones (brother) 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery September 26, 2004 Pocomoke City, Maryland permit. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home Professional Association Dean 103 Linden Avenue, Pocomoke City, Maryland 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Vm (morn my my Immediate Cause (Final disease or condition resulting in death) **Physician** 5 mo /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner rsician and e burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical the phys use as (IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months?
1 Yes 2 No Month 5 Other (specify) P.O. the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 2 No 3 Probably 4 Unknown page 2 should Be Completed 1 🗌 Yes peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has certificate 2,23No of Vital 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Ather (Specify) brothers 200 1 Tes Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division or Attending residence 1 Natural 5 Pending after death. Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29b. Signature and uitle of crtifier 29c. License number 2050) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 GRASSO CANNOU ST SALISBURY 145 31. Date filed (Month, Day, Year) State 7 2004 Registrar

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	Funeral		5. Social Security Number	6. 5			s. last birthday)	If Under	1 Year			8. Date of B	irth		9 Rinthol	lace (State or	Foreign
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Sre	of He	1	20a. Method of Disposition	a.	70		Place of Dispo cemetery, crea	sition (Nam	ne of ther place	9)	Sept	Pember	20c. Loca	ation - f	City or Tov	wn, State	
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Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr 20c8.		21. Signature of Funeral Si	rvice Lice	1,000	1	2:	2. Name an	d Addres	s of Facilit	Yat ic	n Serv	ice	P ∩	Boy	78/	
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×	leath certific attending p	Š	IF FEMALE: 23b. Was decedent pregna		23c. If yes, ou	tcome of preg	nancy						23	ld Date	of deliver		
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9	res that the igned by be detact	H.	Part II. Other significant co	nditions	ontributing to d	eath but not re	esulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco use	a contri	bute to the	e cause of dea	ath?
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Division	of or Attency after death Director:	Certification:		etermined	280. Place	of Injury - At ing, etc. (Spec	home, farm, str cify)	eet, factory,	office			28f. Location (City or To		Numbe	r or Rural	Route Numbe	er,
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Me	rtifying Ph dical Exar	nysician: To the niner: On the b	asis of examir	nowledge, deatl nation and/or in:	occurred a vestigation,	in my opi	e, date and inion, deal	d place, th occurr	and due to the ed at the time,	cause(s) and p	nd man lace, ar	ner as sta	ted. the cause(s)	
	To the within 2. To the complet	Jed	one)		and man	ner stated.		100-	Lineage				00d D-1-	-1	Alamb D		
	J with	~	29b. Signature and title of o	1 K	/				License				29d. Date :	signed	(MORTH, D	⊌y, rear)	
1			NU	a	2			0	1005	8-5	2		/23	10%			
(0)	3		30. Name and address of p					Print)	WA.	189 Kt24	2 (h.					
(Z)	*		9501 014	An.	napoli	3 Ry	1 5u	. 6	20	2	Elli	cox	C- oh	. /	40	2164	2
	Sta		31. Date filed (Month, Day,	9 A 2	000/	gistrar's Sigr	nature L.			,							
	Registr	ar	OLI	N I Z	.004	CHIA.	15. 1	DANK	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** MARTHA SEPTEMBER 17, 6:06 A M KASLOW 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CHEVY CHASE 5600 WISCONSIN AVENUE, #809 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 16, 1926 NEW YORK Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🖫 F 78 Director 107-20-7573 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural; or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No MONTGOMERY CHEVY CHASE Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5600 WISCONSIN AVENUE, #809 20815 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 X No ρ Specify: 3 X Widowed 4 □ Divorced Year or Dates: WHITE Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natue any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CUTLER BELLA SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 6306 VALLEY ROAD, BETHESDA, MARYLAND AMY M. KASLOW, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Remo injury . GARDEN OF REMEMBRANCE CEM. 9/20/2004 CLARKSBURG, MARYLAND □ Other (Specify) of Funeral Service Libense 21. Signatur EDWARD SAGEL FEUNERAL DIRECTION, INC. 23a. Part The the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur of ust only one cause on each line. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER 14 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Greate of Agury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **EMPHYSEMA** 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \[\text{Yes} \] 2 \[\text{No} \] 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Division of Vital Records, Hospital or Attending Physician: within 24 hours after deatl To the Funeral Director: in by

Baltimore, Maryland 21215-0036

P.O. Box 68760.

31 Date filed (Month, Day, Year) State 22 Registrar 2004

29b. Signature and title of certified

29a. Certifie

(Check only one)

Medical

32. Registrar's Signature

Tarsen MI

and address of person who completed cause of death (Item 23a) (Type, Print)

YLENE A. LARSEN, M.D., 5530 WISCONSIN AVENUE, #930

1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D22599

29d. Date signed (Month, Day, Year)

CHEVY CHASE, MD

SEPTEMBER 17, 2004

			1 - For State Registrar	State of Mar	ryland		artment rtificate			nd Me		ene g. No	2004	31	795
	Physici	an	1. Decedent's Name (First, Middle, Last)							2	Date of Death Month	Day	Yeer		of Death
	/Media		James Alfred								Sept.	19	2004		0 р.м
1	Examir	er	4a. Fecility Name (If not institution, give s. Mallard Bay Care					nown, or mbri	Location of I	Death		4c. (County of Death Dorches		
	Funeral		5. Social Security Number 6. Sex		(In yrs. Ia	ast birthday)	If Under		If Under 24	4 Hrs.	B. Date of Birth	l			or Foreign
	Funeral Director			M 2□F	82	Yrs.	Months	Days	Hours	Min.	Month, Day, Sept. 12	Yeer)	922 M	nplace (Stete untry) arylan	ıd
	pu ,		Usuel Residence of Decedent 10a. State 10b. County		10a City	, Town or Lo								404 (Oh Himita
7	ehov	7	MD Dorches	İ	ioc. City	, TOWN OF LO		Camb	ridge					10d. Inside	s 2 No
5	28e-1	Director	10e. Street and Number	cer			10f. Zip (Tuge		10	a Citiz	en of What Co		
Ź	death with the Maryland me 23a or 28e-f ehow		520 Glenburn Ave				101. Zip		21613		.0	-	J.S.A.	unity :	
0	ours after death with the Marylan rel', or Iteme 23a or 28e-f ehow Examiner must be notified at	Funeral		2. Was Decedent Ev	er in U.S	3. 13. V	Nas Decede			n? (Speci	fy Yes or No- can, etc.)		4. Rece - Amer		
0	or Ite		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 21X No		Ì	rres, speci 1 □ Yes 2		Specify:	Pueno Ai	can, etc.)		Black, White Specify: W	nite	
3-003p	"naturel",	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:									•		
Ç	n 72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	tent's Usual kind of work DO NOT use	k done d	uring most o	of working	, 1	6b. Kin	d of Business/l	ndustry	
171	within lene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+))		did						none		
<u>D</u>	Hyg other	a)	17. Father's Name (First, Middle, Last)						18. Mother's	s Name (First, Middle, Ma	aiden S	Sumame)		
/land	should be nd Mental marked o	To B	James A. Kornrum	ρf					Ag	gnes	Hubbard	1			
a	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Typ								Route Number,			ip Code)	
e,	ealth m 27		Joan Wood	sister	20h 01				d., C.			199			
	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 MaRe	emoval from State	Ce	ace of Disponentery, cren	natory or oth	her place		Dai			ation - City or 1	own, State	
Saitimor	it. Partmentant:		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		HOT	y Cros				/25/()4 I nas Fune		er, DE	7 7	
g	permit. Pages Department of Important: If I eny injury or once.		B. Va.	•							oridge,		21613	A.	
-	\$ A		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused th	ne death									Approxima Interval Bi	
	Physician holding physicien and physicien and physicien and physicien and strength physician phy	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a of Due to (or a) Due t	consegu	ence of):	abr	nori	nali	fie	ſ			Onset and	
ROX PR	ath certif ittending or use as	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Ic. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal	death 3 🗌	Ectopic pre					23	3d. Date of deliving Month	/ery Day	Year
r Ö	y th	Physic	9 Unknown	9□ Unknown											
ທົ	sign d be	þ	Part II. Other significant conditions cont mental retain	death but	not resu	lting in the ur	nderlying ca	use give	n in Part I.		23e. Did toba 1 ☐ Yes	- 12	e contribute to	the cause of bably 4	
Vital Record	aw as b	Completed									24a. Was an		24b. Were aut	opsy finding	s available
ř	0 - 0	E									autopsy performe	d?	death?	2 No	Cause of
<u> </u>	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							f Death (Check only one)				
O I O	Physician: rthis certific ral director.	2	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient		R/Outpatien		-	Nursi		5 🗆 Residen			fy)	
UNISION	on the street	atlon:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear)	28b. Time of Injury	M 28	C. Injury Work 1 🔲 Y	at ? 'es 2 □ No		d. Describe how	injury	occurred		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At hor (Specify)	me, farm, stre	et, factory,	office		28	f. Location (Stre City or Town,	et and State)	Number or Rui	al Route Nu	mber,
	he Hospi in 24 hou he Funei pletely fil	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	er: On the basis of er and manner state	xamınati	vledge, death on and/or inv	occurred a restigation, i	t the time in my opi	e, date and p inion, death	place, and occurred	d due to the cau at the time, dat	se(s) a e and p	nd manner as : place, and due !	stated. to the cause	(s)
	To t To t	Σ	29b. Signature and title of certifier	1.				License				_	signed (Month,		
•			Maarso	n xu				10	599	73		4/	20/04		
			30. Name and address of person who con Patricia Johnso	on Do,	100	Bra	Print) mble	2 S7	+, Co	amb	bridge,	n	10 210	613	
	Sta Registr	-	31. Date filed (Month, DEFP)2 2	2004 ²² Registrar's	s Signati	ure A	Brech	20	,						

			For State Registrar	State of Marylan		artment of H rtificate of I		-	giene Reg. No	21111	31796
			Decedent's Name (First, Middle, L	ast)				2. Date of De	ath Da	y Year	3. Time of Death
	Physici /Medic		STEVEN L. LEVY					Septer	bis"	17 2004	+ 1645 M
1	Examin		4a. Feoility Name (If not institution, g		,		Location of Death		4c	County of Dea	th P
	· (gr		Prince 6-en				verly			Prince	6 evges
	Funeral			Sex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under £4 Hrs. Hours Min.	8. Date of Bir (Month, Da	iy, Year)		thplace (State or Foreign ountry)
*	Director		577-82-1110 Usual Residence of Decedent					March	2, 1	977 Wa	shington DC
	yland Now		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Mar B-f st	tor	MD Montgome	erv Silv	er Sp	ring					XXYes 2 □ No
	or 28)ire	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	23a	ral	12309 Treetop Di			20904					es of Americ
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Enaminer must be notified at once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S) in, Mexican, Puert Specify:	pecify Yes or No Rican, etc.))-	14. Race - Ame Black, White Specify:	
21215-0036	hours urel',	d by	3 Widowed 4 Divorced	Year or Dates:			-41		105 1		
15-	n 72 n net	Completed	15. Decedent's (Specify only highest of	rade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	160. K	and of Business	rindustry
12	withi lene. than	шc	Elementary/Secondary (0-12) 12th grade	Coltege (1-4or 5+)		ruction	,		Desi	vate In	duator
	Hyg other	a)	17. Father's Name (First, Middle, La.	st)	COLISE	Luction	18. Mother's Nam	ne (First, Middle			dustry
a	lid be fental rked tic ev	To B	Richard Leon Wil	llis			Vicky	Levy			
Maryland	and A s ma		19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street					1
	and 2 salth in 27 i		Vicky Champion				Dr. Apt				, MD 20904
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		emetery cres	natory or other place	(9)	Date		ocation - City or	
Ë	Pag iment tant: jury c		`4 □Donation 5 □ Other (Spec	city)	Cr	Park ematory		7/04			Maryland
Ball	Departition Depart		21. Signature of Funeral Services Lic	ensee / WSDX		2. Name and Addres 16 Kenned				kins Fu	neral Home
8		į.	23a. Part1. Enter the disease, or co	mplications that caused the death by one cause on each line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	V V	Immediate Cause (Final disease or condition	. Closed 1	read	ikiws				1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	1 1					
	LAdminer	L	Sequentially list conditions,	D		le Ac	4 dew	\			
	ed sit	iner	Sequentially list conditions, in any seal of the cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ieuce oil.						
	xecut and II-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):						
8760,	icate be executed physician and s the burial-transit	dical E		d.							
9	tificat ig phy as th	Φ.							-		
Box	death certific e attending p od for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			-	23d. Date of de	•
Ю. В	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)				Month	Day Year
٥.	that the de ed by the detached		Part II. Other significant conditions	contributing to death but not resu	ıltina in the u	nderiving cause give	en in Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
Vital Records,	sign d be	ed by						10	Yes 2	ØNo 3 □ Pr	obably 4 Unknown
900	aw as t	Completed						24a. Was		24b. Were at	utopsy findings available completion of cause of
Ě	0 - 0	E O						perfo	med?	death?	2 No
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)		
of V	Ø 2. Z	၉	1, Yes 2 □ No	Hospital: 1 Inpatient 2		nt 3□ DOA Othe	er: 4 Nursing H	ome 5□Resid			
n c	ing P	on:	27. Manner of Death 1 □ Natoral 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	0	4TV. U	how injui	ry occurred w	be droving
sio	Attending r death.	cati	2 Accident investigat 3 ☐ Suicide 6 ☐ Could not	he 2004/	15'-15		Yes 2 No			Truck	ural Route Number,
Division	or All	Certification:	4 Homicide determine	28e. Place of Injury - At ho building, etc. (Specify)	Teet, factory, office		City or To	wn, State	12211 4	WIVENSITY
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	a C		Physician: To the best of my know	wledge, deatl	n occurred at the tin			cause(s)		stated Metry / stay
	he Ho n 24 l ne Fu sletely	edical	(Check only 2 Medical Ex	eminer: On the basis of examinat and manner stated.							
	To the within 2 To the complet	ž	29b. Signature and title of certifier	, , , , ,		29c. License	number		29d. Da	te signed (Mont	h, Day, Year)
			Solvado	Alveter De	0	1400	5597	/ .	50	Terber	18,2004
K	(2)		30. Name and address of person who	o impleted cause of death (Item 3747, 3051 Hos	23a) (Type,	Print) (Drive,	chev.	eoh	has	13 land	h, Day, Year) 1/8, 2004
	Sta Registi		31. Date filed (Month, Day, Year) SFP 2. 4 20	32 Registrar's Signal	ture	M. s		7/			

			For State Registrar	1 10400 1	State of	Marylan	d / Depa		t of H	ealth a		•		04	31797
			1. Decedent's Name (Firs	t, Middle, Last)						-		2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		INEZ E	LIZABET	H LAMI	BERT								004	11:50 A _M
	Examin		4a. Facility Name (If not in	nstitution, give :	street and numi	ber)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	th
			NATIONAL	NAVAL	MEDICAL	CENTE	ER			HESDA				MONTGO	OMERY
I	Funeral Director		5. Social Security Number 267–74–5445	10	M 2AF	. Age (In yrs. 97	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 2	6,190	9. Bird	thplace (State or Foreign ountry)
	pur *		Usual Residence of Dece 10a, State 10b.	. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	faryli sho	ō		ontgome	rv	Ga	ithers	hura							1 ☐ Yes 2 🛣 No
	28a-	ect	10e. Street and Number	one gome.			TUILLE	10f. Zip	Code			T	10g. Citize	en of What Co	ountry?
	with 3a or	0	217 Booth S	Street						878			-	ed Sta	
	na 2:	Funeral Director	11. Marital Status		12. Was Deced	lent Ever in U.	.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		I. Race - Ame	erican Indian,
က္	or Ite	Ē	1 Never Married 2	2 Married	Armed Ford	. No		rres,spec 1 ⊟ Yes 2				Hican, etc.)		Black, Whit	
Ö	raff, c	by	3 X Widowed 4 □ D	Divorced	If Yes, Give Year or Dat			ILI Tes 2	ZEN NO	зреспу.			5	pecify: V	√hite
2	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Madical Exstrict must be notified at event.	Completed	15. E (Specify on	Decedent's Edu ly highest grade	cation completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa	ation Juring most	t of worki	ing	16b. Kind	of Business	/Industry
2	ne.	mpi	Elementary/Secondary	(0-12)	College (1-	4or 5+)		maker	e retired)			0	Home	
7	lled w tygie her t		12 17. Father's Name (First,	Middle (ast)			HOME	illa KEL		18 Mothe	r's Name	(First, Middle	1		
anc	ibe fi	Be	Charles Jei									Hayte		umame,	
Ž	d Me d Me mark matic	٦ 2	19a. Informant's Name/R		ne Print)		19b. Mailie	na Address	(Street a			Al Route Numb		Town. State.	Zip Code)
Ma	id 2 s ith an 27 is trau		Louise Alle			r)						thersb			
ē,	Hea Hea tem		20a. Method of Dispositio			20b. F	 Place of Dispo cemetery, crea	sition (Nam	ne of	01 0		Date	20c. Loca	ation - City or	Town, State
OF.	ages ent of rt: # i		1 ☐ Burial 2 XCre `4 ☐ Donation 5 ☐ 0		lemoval from S	iaie [tropol:			, 0	200 200	22 ,	Alexa	andria	, Va.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral		9							ol Fun	eral I	Home	
m	Depared Important Important Info		Cutio	6.6	Dy										Md. 20877
			23a. Part1. Enter the dis	sease, or compli ure. List only or	ications that ca ne cause on ea	used the deat ch line.	h. Do not ent	er the mode	e of dyin	g, such as	cardiac d	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			EUMONIA	1								Onset and Death
	/Medical		resulting in death)		2.	r as a conseq									1
	Examiner		Sequentially list condition	ns,		GESTIV		RT FAI	LURI	Ξ .					
	ed sit	Examiner	Sequentially list condition than, leading to in redicause. Enter Underlying Cause (Disease or injury	ero Z	Due to to	ras a conseq	uence out:								
	and and II-tran	хап	that initiated events resulting in death) Last			r as a conseq	uence of):								
760,	icate be executed physician and s the burial-transit	calE			4										
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Вох	nding use a	N/U	IF FEMALE: 23b. Was decedent preg	nant 2	3c. If yes, outc			Tetasia sa					23	d. Date of del	livery
	that the death certifical ed by the attending phi detached for use as th	Physician/Med	in the past 12 montl 1 ☐ Yes 2 🕱 No	hs?		th 2 □ Feta nt at time of d		Ectopic pro Other (sp.						Month	Day Year
P.O.	at the by th	hys	9 □ Unknown												
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ord	s een s	ted											Yes 2 🗆	740 3 1	robably 4 □Unknown
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<u> </u>	: The cate had page	S										1 X Yes			2 X No
Ž.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?	-	fospital:				. Othe			(Check only			
ō	Physician: 'r this certifica	-: T	1 Yes 2 No		1 (X) In 28a. Date of		ER/Outpatier 28b. Time o		8c. Injury			me 5 Resi			icity)
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Division	Attending r death. sctor: After by the fune	ifica		Could not be determined		of Injury - At h		eet, factory	, office			28f. Location (City or To		Number or Ru	ural Route Number,
ā	s afte	Certification;	4 Homicide		Dulluli	g, etc. (Specit	у)					Ony or 10	wii, Otatoj		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (Certifying Phy Medical Exami											s stated. to the cause(s)
	To the H within 24 To the Fi complete	ledi	one)		and manne										
	To To	Σ	29b. Signarture and title of	or centrier	1					s number	(37 A `	,	Zau. Date:	signed (Mont	ii, Jay, Tear)
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	Physicia	n	1. Decedent's Nam			_					2. Dete of Do Month	Dey	Year	3. Time of Death
	/Medica	1	4a Fecility Neme (MARJ(E.	LEV	LNE		4b. City, Town,	SEPT. or Location of Dea		2004 of Deeth	11:45 PM
	Examine		307	OR CARI						CHEVY C	HASE	MON	GOME	RY
ı	Funeral Director		5. Social Security N	Number 2603	6. Sex			rs. lest birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 H	in. 8. Date of Bi		9. Birthp Cour	place (State or Foreign htry) YORK
	deeth with the Merylend ms 23s or 28s-f show r must be redfind at		Usuel Residence of 10a. Stete	10b. County			10c.	City, Town or Lo	cation				1	0d. Inside City Limits 1 X Yes 2 □ No
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	with the		10e. Street end Nu		COMTO	TTM A T		.,	10f. Zip Code	2015		10g. Citizen of		ntry?
	ne 23e	Funeral	11. Meritel Status	O CONNI		Was Dece	dent Ever in			0015 Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		S.A. ce - Americ	
	or its	DA FO	1 ☐ Never Mar			Armed For 1 Yes If Yes, Giv Year or Da	2 X No	1	f Yes, specify Cut 1 □ Yes 2 🛣 No		erto Hican, etc.)	Specil	ck, White, y: WH	
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au		D De		LFRED		EDELM	IA NINI				REBECCA			
ary S	should nd Men marke umetic	0	19a. Informent's N				MININ	19b. Mailir	ng Address (Stree	t and Number or	Rural Route Numb	per, City or Town	, State, Zip	Code)
Ξ	0 P 2 E		JOYCE	WEINS'	TEIN/	DAUGH	TER	35	GARDEN I	OR., ALE	XANDRIA,	VA. 223	04	
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	Physician /Medical Examiner		23a. Pert1. Enter shock, or head Immediate Cause disease or condition resulting in death)	art failure. List (Final	complicationly one of	cause on e	oug		i hea-		liac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
	ficete be physicients the bur	in/Medicai Examiner	Sequentially list or if any, leading to it cause. Enter Und Ceuse (Disease or that initiated event resulting in death)	r injury	c			o (or es a conseq						
מ	deeth	SICIB	Part II. Other signi	ficant condition	ons contrib	uting to de	ath but not r	resulting in the u	nderlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?
, J	requires that the deeth cert been signed by the ettendin should be deteched for use	by Physician/M	D@	emei	rhic	i					1 🗆	Yes 2□ No	3 ☐ Prof	bably 4 donknown
ecords,	~ 1100	Completed									24a. Was perf	s an autopsy ormed?	av.	ere autopsy findings ailable prior to mpletion of cause death?
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DIVISION OF	l or Attending Physician: effer deeth. Director: After this certific d in by the funeral director.	ation:	27. Menner of Dea 1 ☑Naturel 2 ☐ Accident	5 🗆 Pendir investi	ng gation	28a. Date o (Mont	of Injury h, Day Year,	28b. Time of Injury	We	iry et ork?] Yes 2 □ No	28d. Describe	how injury occur	red	
	s efter de i Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be nined	28e. Plece buildir	of Injury - Ang, etc. (Spe	t home, farm, str ecify)	eet, factory, office			(Street and Num wn, State)	ber or Rura	il Route Number,
		Medical	29a. Certifier (Check only one)	Certifyir 2 Medical	ng Physici Examiner	: On the ba	best of my least of examiner stated.	knowledge, death ination and/or inv	occurred at the trestigation, in my	ime, date and pla opinion, death o	ace, and due to the courred et the time	cause(s) and m , date and place,	anner as s and due to	ated. the cause(s)
	within To the	Σ	29b. Signature and	d title of certifie						se number		29d. Date signe		
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	9		30. Name end edd	ress of person	who comp	leted caus	e of death (I	tem 23a) (Type, A East:	Print) Joppa R	oad, Su	264230	TOCUSO	N, M	121286
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** SEPTEMBER 24 2004 8:20 P M JAMES FRED MILLS, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7635 POPLAR STREET CHARLOTTE HALL ST. MARY'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **X**XM 2□ F Months Hours Min 215-26-0261 79 22, Director JAN. 1925 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other treumatic event, the Medical Events and once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No Directo MD ST. MARY'S CHARLOTTE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7635 POPLAR STREET U. S. A. 20622 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ﷺ es 2 ☐ No If Yes, Give Year or Dates: ₩.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 20XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) TREE TRIMMER TREE TRIMMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES FRED MILLS MARY ELIZABETH CLAPSADDLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38070 HUNTER COURT CHARLOTTE HALL, MARYLAND 20622 KENNETH E. MILLS, SR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SPETEMBER 1 Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 29, 2004 ^¹ 4 □ Donation 5 □ Other (Specify) CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A. 1 Bailon Job M00641 30195 THREE NOTCH ROAD CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 es 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 3 PNO 1 Tes 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 3□ DOA P 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 Natural 2 Accider Hospital or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No M Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier D5906 SEPTEMBER 27, 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Prince Frederick MD 20678 C. Parl 110 1402014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 27 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea **Physician** 2:05 Α Frederick Thomas Moreland September 27, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 💢 M 2 🗆 F Months Hours 79 Yrs Director July 1, 1925 219-16-1633 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other then "naturel", or items 23a or 28e-f shov other treumatic event, the Nadical Examiner intel to maintail at 1 Yes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23311 Point Lookout Road Funeral 20650 USA 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking permit. Pages 1 and 2 should be filed Depriment of Health and Mental Hygin Impurtant: If Item 27 Is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred A. Moreland Mary Agnes Countiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Veronica Moreland/Wife 23311 Point Lookout Road, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Our Lady's Cemetery Oct. 1, 2004 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Leonardtown, Maryland 20650 P.O. Box 270 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia Arr respirato shock, or heart failure. List only one cause on each line. Interval Betwe Immediate Cause (Final Physician disease or condition resulting in death) mules /Medical Due to (as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 @Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ₺ No 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4€Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospitel or Attending P24 hours after death.Funerel Director: After t Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VO mas 30. Name and and ess of person who come tee cause of death (Item 23a) (Type, Print) Dr. James P. Jarboe, 24035/Three Notch Road, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32 Segistrar's Signature SEP 2 8 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

CHARLOTTE ROBERTSON MCRAE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #17,9 HCAD, 9-24-04, per Certificate of Death 1- Stete Amend #17 Registrar FHDR #17 1. Decedent's Name (First, Middle, Last) Reg. No. 2. Date of Death 3. Time of Death Month Day Physician September 18, 2004 0915 Robert Jerry Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year Mar. 8, 1 If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Hours 1**X** M 2 ☐ F 215-58-0533 1953 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location iortant: If item 27 Is marked othar than "natural", or Itams 23a or 28a-f show injury or othar traumatic avent, Iha Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1916 Harbinger Trail 21040 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify White 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Landscaper 11 Landscaping 17. Father's Name (First, Middle, Last) Leland Louis Cullum 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 Is marked ot Be Robert Jerry Miller Sr. Caroline Hughey ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobbie Jean Miller/daughter 2120 Glen Cove Rd, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Arundel Crematory 22, 2004 Odenton, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Bevel Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (erebral embol /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last ardiac Due to (or as a consequence of): Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the al d be detached for ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Acciden 5 Pending investigation 1 Tyes 2 🗆 No Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel or A within 24 hours after To the Funaral Direc 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) September 18 0018

State Registrar

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m. W

egistrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2004

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			For State Registrar	State of	Maryland		artment of F		d Mental Hy	giene Reg. No.	04	3 : 8	03
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	Physici /Medic		Luella Badorf M	lac Donald						ber 20,	2004	7:45	ам
	Examin		4a. Facility Name (If not institution, g	ive street and numb	oer)		4b. City, Town, o	or Location of D	Death	4c. Coun	ty of Death		
			Holy Cross Hosp		A = - (1= 1	and think to all	Silver If Under 1 Year		Her I a B		tgome		
	Funeral Director		5. Social Security Number 6. 213-38-2176	Sex 7. 1 ☐ M 2X☐ F	Age (In yrs. I	4 Yrs.	Months Days		Min. (Month, Da	iy, Year)	Cour		
			Usual Residence of Decedent		9	4			Aug. 25	5, 1910	Peni	ısylva	nia
	yland		10a. State 10b. County		10c. City	. Town or Lo	cation				1	0d. Inside Ci	•
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	or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen o	f Whal Cour	try?	
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	er de Itams	Funerai	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of I f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		ace - Americ lack, White,		
36	hours after death with the Maryland lural', or Itams 23e or 28e-1 show at Exercipat must be notified at	by F	1 Never Married 2 Married 3 Midowed 4 Divorced	1 □ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🔯 No	Specify:		Spec	eity: Whit	e	
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nd		ø	17. Father's Name (First, Middle, Las	st)					Name (First, Middle,		ame)		
aryland	2 should be and Mental la marked o	ို	Harry Badorf	C		400 44 300			es Stauffe		21.1	0	
Mar	12 sh h and 7 la m traum		19a. Informant's Name/Relationship						r Rural Route Numb	•		Code)	
ص ر	1 and Healt am 2 ther		Frances Miller 20a. Method of Disposition	/ Daugnte					Kensingto Date	200 Location		wn, State	
Baltimore,	ages int of t; H it		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate Pa		sition (Name of natory or other pla Memoria	Ser Ser	otember 25 2004				112
Ħ	artme ortan Injury		21. Signature of Funeral Service Lic			Par	. Name and Addre	ess of Facility	2001	Rockvi.	lle, N	arylar	1d
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic av pnce.		Anne Ma	Ne Pai	ker	Fr	cancis J.	Collir	ns Funeral Lvd, W, Si	Home	Inc	MD 20	2001
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underthing	aConge Due to (or	stive as a consequ	Heart Jence of): Failu	Failure	ng, such as car	rdiac or respiratory a	rrest,		Approximate Interval Bett Onset and D	ween
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	. Funga	1 Urin	arv Tr	act Infe	ction					
oʻ	cate be executed oblysician and the burial-transit		resulting in death) Last		as a consequ								
8760,	ate be hysici ihe bu	licai		d. Perip	heral	Vascul	ar Disea	se					
.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 Fetal nt at time of de	death 3	Ectopic pregnanc Other (specify)	у			ate of deliver	_	/ear
Δ.	as this	by	Part II. Other significant conditions	_	th but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use co		e cause of dably 4 DU	
ecords,	w require been sign	Completed	Right Leg Ulcer						24a. Was	an 24h	Were auto	osy findings a	available
Re	ne lav s has ge 2	E C							autor	psy ormed?	prior to cor death?	npletion of ca	ause of
Vital	ician; Th certificate rector, pag	e Co	25. Was case referred to medical		· · · · · · - ·		······································	26 Place of	1 ☐ Yes Death (Check only of	20 No	1 Yes	2 No	
		o B	examiner? 1 ☐ Yes 2 🗙 No	Hospital: 1 X Ing	patient 2 🗀	ER/Outpatien	it 3 DOA Ott		ng Home 5 Resi		ther (Specifi	r)	
ion of	ding Ph After th tuneral	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. ate of (Month,		28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe			,	
Division	al or Attandi s after death it Director: A id in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place o	f Injury - At ho j, etc. <i>(Specif</i> y		eet, factory, office		28f. Location (City or Tox	Street and Nun wn, State)	nber or Rura	Route Numi	ber,
	To the Hospital or Attantwithin 24 hours after deatl To the Funarat Director:	edical (is of examinat				place, and due to the occurred at the time,				}
	To the within To the Comp	ž	29b. Signature and title of certifier	V 1.0		,	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)	
)	10		Duma	Kiron	raf	1	D5	8965		Septem	ber 2	0, 200	4
	l		30. Name and address of person wh Saima Khawaja,				Print)		ockville	MID 2005	.2		
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	Registi	ar	SEP 22 20	JU4 /		1	popular						

			1 - For State Registrar		of Marylan		artment of tificate of			Re	g. No. 0) ,	31804
	Physicia	an	1. Decedent's Name (First, Middle							2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Pearl Elizabet				4b. City, Town,	or I continue		SEPT.	20 4c. Count	2004	12:42
	Examin	er	4a. Facility Name (If not institution) Future Care- (-			Arnold		or Death		Anne		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under		B. Date of Birth			nplace (State or Foreign
	Director		213-58-3823	1□M 2 @ F	86	Yrs.	Months Days	s Hours	Min.	Month, Day,	1917	Mary	and
	DC ,		Usual Residence of Decedent		100 Cib	y, Town or Lo							10d Inside Circlinia
	shov	ř	10a. State 10b. County				Cation						10d. Inside City Limits 1 ☐ Yes 2 🕬o
	28a-1	Directo	Maryland Baltin	nore	Tir	nonium	10f. Zip Code			10	g. Citizen of	What Co	17.00
	with	₫	2300 Dulaney Va	11av Rd	# ₹0.8		21093				Jnited		
	d within 72 hours after death with the Maryland piene. Ir than "natural", or itams 23a or 23a-1 show The Medical Exantine must be notified at	Funeral	11. Marital Status	12. Was De	ecedent Ever in U.	S. 13.	Was Decedent of	Hispanic Ori	igin? (Spec	ify Yes or No-	14. Ra	ce - Amer	rican Indian,
٥	or itan		1 Never Married 2 Marri	ed 1 TYe	Forces? s 2 No		f Yes, specify Cu 1 ☐ Yes 2 2 No			ican, etc.)		ck, White	e, etc.
3-003p	72 hours after natural', or ita	d by	3 Widowed 4 Divorced	If Yes, (Year or	Dates:		1 195 2 2 1 NO	з зресну.			Specia	whi	te
ភ្ន	72 h "natu	Completed	15. Decedent (Specify only highes	's Education t grade complete	d)	(Give	lent's Usual Occu	e durina mos	t of working	7	6b. Kind of B	lusiness/l	ndustry
7	within lene. than "	du	Elementary/Secondary (0-12)	College	(1-4or 5+)		00 NOT use retir nemaker	0 0)			own ho	ome.	
2	e > 4 €		17. Father's Name (First, Middle, I	Last)		1101	Hemaker	18. Mothe	er's Name (First, Middle, M			
yland	ld be ental kad o	To Be	T.1 D1.1					Donas	Vana	. L _			
3	shou ind M mar	<u></u>	John Deuchler 19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Stree		L Kana er or Rural i		City or Town	, State, Z	ip Code)
Mar Mar	alth a alth a 27 is		Bryan Miller/ so	on		114 M	arket St	. Anna	polis	, MD 21	1401		
altimore,	of He of He litam		20a. Method of Disposition 1 Burial 2 Cremation		20b. P	lace of Dispo emetery, crer	sition (Name of natory or other pl	ace)	Da	te 2	Oc. Location	- City or T	Fown, State
Ĕ	Pagment ant: i		'4 □ Donation 5 □ Other (Sp		Bal		e Cremat	- 1	_				-
gall	permit. Pages 1 and 2 should be fi Department of Health and Mental F Important: If Itam 27 is marked ot any injury or other traumatic ever		21. Signature of Fugeral Service &	Row	worker								ral Home, Inc MD 21401
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha only one cause or	It caused the death n each line.	n. Do not ent	er the mode of dy	ving, such as	cardiac or	respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. 1	UNG to (or as a consequ	CAR	LLINO	ma					Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a consequ	uence of):							
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o O	res that the de signed by the a be detached f	ysic	1 ☐ Yes 2 Î ☐ No 9 ☐ Unknown	9 Uni	gnant at time of do known	eath 5	Other (specify)						
ŗ.	that led by deta		Part II. Other significant condition	ns contributing to	death but not resu	ulting in the u	nderlying cause g	iven in Part I.		23e. Did toba	acco use con	tribute to	the cause of death?
g	quires n sigr	d by								1 ☐ Yes	s 2□No	3 ☐ Pro	bably 4 Duknown
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Vital Records	ysician: The taw is certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Check only one)		
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	ding P. h. After t	lon:	27. Manner of Death 1 Natural 5 Pending	9	te of Injury onth, Day Year)	28b. Time of Injury	W	uryat ork?]Yes 2.∐I		d. Describe how	v injury occur	red	
<u>s</u>	or Attanding after death. Director: After in by the fune	icat	2 Accident investig	not be	ice of Injury - At ho	me farm str				tf. Location (Str	eet and Numb	per or Rur	al Route Number.
DIVISION	l or A after Direct	Certification:	4 ☐ Homicide determi	bui	ilding, etc. (Specif)	<i>(</i>)	oot, raciory, ornot			City or Town,			
	To the Hospital or Attant within 24 hours after deati To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my kno basis of examina anner stated.	wledge, death tion and/or in	occurred at the vestigation, in my	time, date an opinion, dea	d place, an th occurred	d due to the car d at the time, da	use(s) and mate and place,	anner as s and due t	stated. to the cause(s)
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	->-0) mone	5 1	ND		DS	75	31	5	EPT.	20	2004
			30. Name and address of person	completed ca	use of death (Item	23a) (Type,	Print)						2004
_			Mohet Neg	7,86	of VeTe	ran	s Hin	14, 1	21/11	EVSVI	11e	MI	21108
	Sta		31. Date filed (Month, Day, Year)	2004 32	, Figistrar's Signa	ture							
	Registr	aı	JEP 4	C 2004	TOOK .	10. 19	Devel						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Donald. Ralph Nagel. II September 26. 2004 10:55 Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jr. Order Cemetery Preston Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 06/11/83 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1[**X**M 2□ F 21 219-02-7338 Maryland Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State rel', or items 23a or 28a-f ehow Exerciner must be notified at 1 →Yes 2 No MD Caroline Denton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 517 Market Street 21629 United States Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes **ZXN**o If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. item 27 le marked other then "natur other treumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald R. Nagel Joan M. Chupek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an Donald R. Nagel/Father 302 Vesper Ave. Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it eny injury or o 1

Burial 2 □ Cremation 3 □ Removal from State Jr. Order Cem. 09/30/04 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A.
216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Contact Shotgun Wound to the Head /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1△ Yes 2 □ No Yes Yes 2 □ No Division of Vital Hospital or Attending Phyelcien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) at Scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: After 09-26-2004 Found AM 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Subject shot self. Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Linchester Road, 3 Suicide 4 Homicide determined Cemetery within 24 hours a To the Funeral I Preston, Maryland. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Pamela E. Southall. M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State STATE AND SEP 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Year **Physician** Nelson Catherine Cavanugh September 25, 2004 8:30 a.m /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Il Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ☐ M 2 ■ F Months Yrs. 074-22-9459 74 July 30,1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ir than "natural", or items 23a or 28e-f show the Medical Examinating be collified at 1 ☐ Yes 2 No Director Lexington Park St. Mary's Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 46874 Flower Drive 20653 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ■ Marned 21215-0036 1 ☐ Yes 2 ♣ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is marked oth any injury or othar traumatic event once. Be Sarah Kennedy Henry Newhouse 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Nelson / Husband 46874 Flower Drive, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9-30-2004 Charlotte Hall, MD Brinsfield-Echols * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Fineral 539 Moj095 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Parm. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death A cute Respiratory Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Psobably 4 □ Unknown peeu gny thmias Cardine 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 papatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To within 24 inc...
To the Funerel Director: Auc...
To mpletely filled in by the funeral directors. After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident M 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Diractor: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 36206 Women. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOllywood MD 2063A KiraN Meuta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 8 2004 > Registrar

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	dical niner	A - Physician Alle	ame (If not institution, g	rive street and number)			4b. City,	Town, or Location	of Death		4c.	County of Death	- 	
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Funer	al	5. Social Sec		. Sex 7. Ag		ast birthday)	If Unde Months	1 Year If Under Days Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth	place (State or ntry)	Foreign
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and	į.	10a. State	nce of Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City	Limits
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Z # # #	Director	10e. Street a	nd Number				10f. Zij	Code			10g. Citiz	en of What Cou	ntry?	
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deat deat	Filheral	11. Marital St	atus	12. Was Decedent Armed Forces	?	5. 13.	Was Dece	dent of Hispanic Or cify Cuban, Mexical	igin? (Spec	cify Yes or No Rican, etc.)	p- 1	4. Race - Ameri Black, White,		
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	9		Name (First, Middle, La	st)				18. Moth	er's Name	(First, Middle	, Maiden	Sumame)		
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re, Maryiand 1 and 2 should be file 1 Health and Mental Hy Item 27 Is marked oth			nt's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	(Street and Numb	er or Rural	Route Numb	er, City or	Town, State, Zi	Code)	
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Ore, pes 1 ar of Hea if item			of Disposition al 2 ☐ Cremation 3	♣ Removal from State		ace of Dispo						cation - City or T		
timor : Pages tment of tent: If it		-	ation 5 Other (Spe		Milfo			ty Cem.				ford, DE		
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item: any inlury or other	once.	21. Signatur	e of Funeral Service Li	censee				ocust St.					•A•	
		23a, Part1,	Enter the disease, or co	omplications that cause	d the death				<u> </u>		·	21013	Approximate	
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Physicia /Medic		disease or di resulting in d	ondition death)	a. Jue to (or as		ence of):							10 00	./>
Examin	er	4		Cere	bral	Va:	scul	ar acc	ider	7+			5 yea	¥5
		Sequentially it any, luadin cause Ente	list conditions, g to immediate r Underlying ase or injury	Dua to (or as	a noneag	ieuce oil):								
cuted nd ransi	Fyaminer	Cause (Dise that initiated	events	c										
cords, P.O. Box 68760, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ŭ		eam) Last	Due to (or as	a consequ	uence of):								
6876 ificate b g physic	100		`	d										
× 6 Sertifii ding I	Day acioiom de	IF FEMALE:		23c. If yes, outcome	of pregna	ncv					2	3d. Date of deliv	erv	
Bo eath (atten		23b. Was de	ecedent pregnant east 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal	death 3	DEctopic p				-	Month	•	эаг
O the definition of the defini	1	9 □ Un	s 2 🖾 No known	9☐ Unknown										
that seed by detail	9	Part II. Other	significant condition	s contributing to death	but not resu	ulting in the u	inderlying	cause given in Part	I.	23e. Did	tobacco u	se contribute to	he cause of de	ath?
rds quire an sig	7	Die	betes me	litus,	hyp	erter	15/C	7		10	Yes 2	BNo 3□Pro	babiy 4 ∐Ui	iknown
aw re	3									24a. Was		24b. Were aut	opsy findings a empletion of ca	vailable use of
The I	Post of Case of	5								perfo	ormed? 2 ☑ No	death?	2□ No	
ien:			e referred to medical		• 1				e of Death	(Check only	one)			
hysic his ce		1 Tes	2 12 No	Hospital: 1 Inpat		ER/Outpaties			-			Other (Speci	fy)	
ing P		27. Manner 1 Natu	ral 5 Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury		28c. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe	now injury	occurred .		
ISIO Itend Geath Hor: /		2 ☐ Acc 3 ☐ Suid	ide 6 Could no	t be Oss Blace of Ir	niury - At ho	me farm et	M reet facto			28f. Location	(Street and	d Number or Rui	al Route Numb	10 <i>f</i> .
Division of Vital Records, P.O. Box to a stending Physicien: The law requires that the death cer after death. Burector, After this certificate has been signed by the attendir in whe fundated for use		4 ☐ Hor	nicide determin	building, e	tc. (Specify	y)	1001, 12010	y, omco			wn, State,			
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy monatolar triand in by the innest director page 2 should be detached for use as it.			r 1 Certifying	Physicien: To the bes	t of my kno	wiedge, deat	th occurre	at the time, date a	nd place, a	and due to the	cause(s)	and manner as	stated.	
ne Ho n 24 h ne Fui		29a. Certifie (Check one)	only 2 Medical E	xaminer: On the basis and manner s		tion and/or in	vestigatio	n, in my opinion, de	ath occurre	ed at the time,				
To the To the To the		29b. Signatu	re and title of certifier	. 4 -1			29	c. License number	2			e signed (Month		Λ
		g	Spane	on do				H00599			_	tember 2		'
		30. Name a	address of person w	ho completed cause of			Print)	t, Can	· h · ·	dea	nse	7 71/2	/2	
	0	31. Date file	d (Month of Mari)	150/ /U	rar's Sinna	mbl	1	Lan.	115/1	uge,	190	0-101)	
Rec	State sistra		o Impant Solling	3 20042. Regis		15	A DOL	1						

			1	State of Maryland / State of Maryland /		tment of H ificate of L		ntal Hygie Reg.	2.11111	31808
1				Decedent's Name (First, Middle, Last)			2	Date of Death Month	Day Year	3. Time of Death
		Physicia /Medica		Frances Wathen Owe	ens			SEPTEMBE		04 02:05a ^M
		Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
	П			St. Mary's Hospital	in the standard of	Leon	ardtown If Under 24 Hrs. 8	Date of Birth	St. Mary	
		Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yearch 5,	1939 Mai	nplace (State or Foreign untry) Cvland
	Ц.	Director	-	219-36-8097 65 Usual Residence of Decedent			I I	arch J,	1737 Hai	yrand
	1	Jand I o w	_	10a. State 10b. County 10c. City, To	wn or Loca	ation				10d. Inside City Limits
		war st	हैं।	Maryland St. Mary's		Leona	rdtown			1 Yes 2 No
		or 28	Director	10e. Street and Number		10f. Zip Code			Citizen of What Co	,
		23a		22794 Lawrence Avenue	1		650		Inited Sta	
		ltams Itams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ■ No	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Speci In, Mexican, Puerto Ric	an, etc.)	Black, White	
Ç	ر د	I', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ■ No If Yes, Give Yes or Dates:	11	☐Yes 2 No	Specify:		Specify: Wh:	ite
5	5	atura cale			a. Decede	nt's Usual Occup	ation during most of working	161	. Kind of Business/	Industry
ž	2	an "n	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. Di	O NOT use retired	d)			
2	7	giene /giene /giene /giene /giene	Completed	12	Bea	utician	18. Mother's Name (i		Cosmetolog	39
		tal Hild oth	Be	17. Father's Name (First, Middle, Last)						
-	yla Y	nauka narka natic	2	George R. Wathen 19a. Informant's Name/Relationship (Type, Print) 15	9h Mailine	Address (Street	Margaret and Number or Rural F			Zin Code)
	Ma	d 2 st th and 7 Is n traun		toal militaria ramara and control of the control of	•	•	St. Inigoe			
	ტ ტ	1 and Healt tam 2 thar	-	20a Mathod of Disposition 20b. Place	of Dispos	ition (Name of atory or other place	Dat		c. Location - City or	
	<u>o</u>	ages ant of it: If if	1	1 ■ Burial 2 □ Cremation 3 □ Removal from State		ius Cem.		004 Lec	nardtown	, Maryland
3	Baltimore, Maryland 21219-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiem 27 is marked othat than "natural", or itams 23a or 28a-f show any injury or othar traumatic event, if a Madical Erami sermusi for rediffied at once.	1	21. Signature of Funeral Service see			ss of Facility Brin			
ſ	ñ	Der Tie		Edward N. Brinsfield, Jr. M00052	2 22	955 Holl	ywood Road	, Leonai	dtown, M	20650-0279
				23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dyin	ng, such as cardiac or i	espiratory arrest	,	Approximate Interval Between O <u>ns</u> et and Death
	ı	Physician	İ	Immediate Cause (Final disease or condition resulting in death)	m 1	0121	he lung.			8 me.
		/Medical Examiner		resulting in death) Due to (or as a consequence)	ce of):		,			
	18	_xaiiiiio.	-	Sequentially list conditions, Due to for as a consequence	ea offi:					
		ted nsit	nine	cause. Enter Underlying Cause (Disease or injury						
	,	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	ce of):					
	8760,	ysicia	dicai	d						
(89	ntifica ng ph	Med	IF FEMALE:						
	Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal dea		Ectopic pregnancy	/		23d. Date of dea Month	ivery Day Year
		the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 □	Other (specify) _				
	<u>.</u>	that the de led by the detached		Part II. Dther significant conditions contributing to death but not resulting	g in the un	derlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
	ds,	uires tha signed to be det	d by					1 Tes	2 □ No 3 P	obably 4 Unknown
	Records, P.O	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Completed					24a. Was an	24b. Were at	utopsy findings available
S	Re	The lav	фшо	·				autopsy performe 1 Yes 2		completion of cause of
OWENS		i ician : Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Death	-		
	of <	Physician: r this certifica ral director, p	To B		Outpatient	3 DOA	100		e 6 □Other (Spe	cify)
		ng Pt		1 Natural 5 Pending (Month, Day Year)	b. Time of Injury	28c. Injur	rk?	d. Describe how	injury occurred	
FRANCES	Sio	Attandi death. ctor: A y the fu	cati	2 Accident investigation	form stre		Yes 2 No	of Location (Street	et and Number or R	ural Route Number
FR	Division	or At after d Diraci in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	, rarm, stre	est, ractory, onice		City or Town,		
	_	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physicien: To the best of my knowled (Check only 2 Medicel Examiner: On the basis of examination	dge, death and/or inv	occurred at the ti	me, date and place, ar opinion, death occurred	d due to the cau	se(s) and manner as and place, and due	s stated. e to the cause(s)
		the H	Medical	and manner stated. 29b. Signature and title of certified		29c. Licens	se number	29d	. Date signed (Mon	th, Day, Year)
		vith con	-	MAM Juno			285		9-28-6	
				30. Name and address of person who completed cause of death (Item 23:	la) (Type. I	Las	- 0 7		1 -0 2	
	6	10-		William D. Boyd II, M.D., 25365			t Road, Led	nardtow	n, MD 206	50
(-/0	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	9					
		Regist	rar	SEP 2 8 2004 Mayor L	7 19	parti				

State of Maryland / Department of Health and Mental Hygiene State Amend Items 23a, 24a per Dr., Certificate / 2004 hb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2004 Hamilton Pauley NÓŐN Charles Sept.26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26477 Barclay Road Marydel Under f Year Caroline If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2□ F Hours Director 61 228-56-8048
Usual Residence of Decedent April 23, 1943 Virginia the Manyland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be nytified at 1 ☐ Yes 2√2 No Directo Maryland Caroline Marydel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? With or items 23a or 26477 Barclay Road Funerai death 21649 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 Divorced 'natural' Caucasian Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nı any injury or other fraumatic event, its Media 0006. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Food Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Scott Avery Pauley
19a. Informant's Name/Relationship (Type, Print) Ellen Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27940 Burrsville Road, Denton, Maryland 21629

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Donna Sarver
20a. Method of Disposition Sister 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 9 9/27/2004 Dover, Delaware 21. Signature of Funeral Service Licensee Moore Funeral Home, 2nd St , Ma.21629 1/lock 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Prostate Cancer Metastic. Approximate Interval Between Onset and Death Prostate Cancer Metastic Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records. Yes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 ₹ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the measure.

within 24 hours after death.

To the Funeral Director: At investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Md. 21636 Brian M. Diamond, MD, 215 Old Town Road, Goldsbore Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 7 2004 Registrar

			1 - State Amend Item	State of Maryla per phy G83	odio Pero	artment of Harificate of	lealth and M Death	lental Hyg	iene	31810
			Decedent's Name (First, Middle, Las	st)			2000.	2. Date of Deat		3. Time of Death
	Physicia	an	Louise Gertrud		Louise	O'Dell 1	Park	Month Sont omb	Day Year er 15, 2004	
	/Medic Examin		4a. Facility Name (If not institution, give		20220		or Location of Death	рерсешь	4c. County of Dea	
	Examin	· .	Montgomery Gener	al Hospital		01nev			Montgom	erv
T	Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	O Bir	thplace (State or Foreign
	Director		534-12-4612		82 Yrs.			Feb. 21,	1922 M	chigan
pue	A I		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
Mary	f she	ō	Maryland Montgo	mery S	ilver S	nring				1 ☐ Yes 2X No
adt	28a-	Director	10e. Street and Number	nery	TIVEL O	10f. Zip Code		1	0g. Citizen of What Co	ountry?
h with	3a o		3406 Chiarrials Co	Dlda 4'	7#2D	209	0.6		USA	
de a la	SEG	Funerai	3406 Chiswick Co	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	
prefront the Maryland death with the Maryland	or It		1 Never Married 2 Married	1 ∐Yes 21∑No If Yes, Give		1 ☐ Yes 2 ☑ No			Specify: Wh	
hours	ural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	10. D					
7.0	nat	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business	rindustry
idim	then to M	mc d	Elementary/Secondary (0-12)	College (1-4or 5+)	Sec	retary	-	1	U.S. Gover	nment
filad	Hyg other	O I	17. Father's Name (First, Middle, Last)				18. Mother's Nam			
PA PA	fenta rked tic ev	0 B	William Arthur C	'Dell`			Effie	Youngedy	'k	
, da	and h		19a. Informant's Name/Relationship (Гуре, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number	, City or Town, State,	Zip Code)
pue	n 27 in 27 ier tre	ll g	Christine P. Vent			Hamblet	on Road,			
4	H ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domous from State		natory or other pla	сө) Septe	ember 18	20c. Location - City or	Town, State
0	Mar it ment		*4 ☐ Donation 5 ☐ Other (Specify	y) 1	Metropol Cremat	ory		004 A	lexandria,	Virginia
octanos I a	Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	e Datike	Fr	Name and Address J.	Collins :	Funeral	Home Inc.	
	10200		23a. Part1. Enter the disease, or com	plications that caused the de					ver Spring	MD 20901 Approximate
			shock, or heart failure. List only	one cause on each line.	satii. Do not ent	er the mode or dyn	ng, soon as cardiac	or respiratory and	651,	Interval Between Onset and Death
	nysician /Medical	9 1	disease or condition resulting in death)	a Pulmonary H		sion				
	xaminer		2.0	Due to (or as a cons						
		ē	Sequentially list conditions, if any, leading to immediate	b. Pulmonary E	equence of):					
000	id ansit	Examine	Cause. Enter Uniterlying Cause (Disease or injury that initiated events	c.						
	ohysician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
400	hysic the bi	dicai		_ d						
topicoso od osocijimos descel od sedenastimos mel od T	attending p	0	IF FEMALE:	22e If yes outcome of pre-						
d d	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
d od	/ the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	i death 3					
that	ed by t		Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
de desirio	n signi	d by	Renal Failure, Ch	ronic Obstruc	tive Pu	lmonary	Disease	1 □ Y€	es 2 🙀 No 3 🗆 P	robably 4 Unknown
aimout out	s been si	ompieted				-		24a. Wasa		utopsy findings available
7	te has	mo						autops perform	ned? death?	completion of cause of : 2□ No
		C	25. Was case referred to medical				26. Place of Deat	h (Check only on		20110
Ohusioism	direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott	ner: 4 Nursing Ho	ome 5 Reside	ence 6 Other (Spe	city)
			27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju Wo	ry at	28d. Describe ho	ow injury occurred	
Assertion	tor: Al	catic	2 ☐ Accident investigation			M 1	Yes 2 □No			
A 444	after death. Director: A J in by the fu	Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
- les	urs le		20a Carifier 15 Cartifying Bh	uveiglers. To the boot of my l	ranuladas dasti	b		and due to the or		
0	24 hours after e Funeral Dire	Medical	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exar	iysician: To the best of my k niner: On the basis of exami and manner stated.	ination and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner a: ate and place, and du	s stated. e to the cause(s)
44.0	within 24 ho To the Fune completely fi	Mec	29b. Signature and title of certifier	and married stated.		29c. Licens	se number	2	9d. Date signed (Mont	h, Day, Year)
F	- s F Ó		Dr. Litize He	Les - Musel	nL	Doos	8542	.5.	EPTENBER,	18. 2004
	10		30. Name and address of person who					0.	1	1
			Libuse Heinz-Mor			,	ia Avenue.	Wheat	on, MD 209	02
j	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		Sporks				
	Registi	rar	SEP 22 200	14 Demara		pours				

		·	1 - For State Registrar	State of M	Marylan		artment rtificate					Reg. No.	004	31811
>	Physici /Medic Examin	al	1. Decedent's Name (First, Midde Irvin Morris I 4a. Facility Name (If not institution Shady Grove Ad	Parsley, Sr.	er)		4b. City, To				2. Date of De Month Septeml	Day ber (04 4:05 a M
	Funeral Director		5. Social Security Number 219-07-4044	6. Sex 7	Age (In yrs. i	last birthday) Yrs.	If Under 1		If Under 2 Hours	Min.	8. Date of Birt (Month, Da	th y, Year)	9. Bi	rthplace (State or Foreign
	ie Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. Count Maryland Montg			y, Town or Lo	ourg							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 2	ral Dire	10e. Street and Number 102 Spring Str				10f. Zip C	77			Ų	nite	d Stat	es
900	ours after dei ral', or Itams Exaciliter	Completed by Funeral	11. Marital Status 1 □ Never Married 2√2 Ma 3 □ Widowed 4 □ Divorce	If Yas, Giva	is? ⊒No		Was Deceder If Yes, specify 1 ☐ Yes 2	y Cubar	spanic Orig n, Mexican Specify:	jin? (Spec Puerto F	eify Yes or No Rican, etc.)	•	Black, Wh	erican Indian, ite, etc. hite
21215-0036	d within 72 h piene. r than "natu ine Medical	ompleted	15. Decede (Specify only high Elementary/Secondary (0-12) 1 2	ont's Education est grade completed) College (1-4c	or 5+)	(Give	dents Usual (kind of work DO NOT use Station	done di retired)	uring most		g		nd of Busines.	s/Industry
Maryland;	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle Ernest Thomas								(First, Middle, Boone			
ore, Man	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; if item 27 is marked other than "natural", or itams 23a or 28a-f show appropriant; if item 27 is marked other than "natural", or litems 23a or 28a-f show any joury or other traumatic avent. The Modical Exercities is at the indifferent ange.		19a. Informant's Name/Relation Frances Parsle 20a. Method of Disposition	y, Spouse	1 0	102 S		Str	eet (Gaith Da		g, M	r Town, State, D 2087 cation - City o	7
Baltimore,	permit. Page Department of Important; if any injury or any injury or ance.		1 Burial 2 Cremation 4 Donation 5 Other (Specify)		t Linc	oln Cr	ema Address	tory	2004 Simp	le Tri	Bre	ntwood , 1040	Rockville
8760,	cate be executed / Medical and physician and the burial-transit	ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequal as a consequal	th. Do not enter the position of the position	ser the mode of	of dying	, such as o	eardiac or			J	Approximate Interval Between Onset and Death
.O. Box 68	death certifii ie attending p od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	1 2 □ Feta tat time of d	Ideath 3[□Ectopic preg □ Other (spec					2	23d. Date of de Month	elivery Day Year
Ω.	es be	by	Part II. Other significant condi	tions contributing to deat	h but not res	ulting in the u	nderlying cau	ise give	n in Part I.		23e. Did to		_	to the cause of death? Probably 4 Unknown
Vital Records,	The taw ate has b page 2 si	Completed									24a. Was autop perfo 1 Yes			
oţ	Attending Physician; Thradeath. setor: Atter this certificate by the luneral director, pag	tion; To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc inves	Hospital: 15 Imp.		ER/Outpatier 28b. Time of Injury		c. Injury Work	r. 4□ Nui	rsing Hom 2	(Check only one 5 ☐ Resident	dence 6	3 □Other (Sp y occurred	ecify)
Division	Dir	Certification;	3 Suicide 6 □ Coul	d not be 28e. Place of	Injury - At ho etc. (Specif		reet, factory, o	office	-	2	8f. Location (\$ City or Tox	Street and vn, State)	d Number or F)	Rural Route Number,
	the Hospital	edicai (ring Physician: To the be al Examiner: On the basi and manner	s of examina									
)	To the within To the Comple	Z	29b. Signature and title of certif	mon	Be	0,4	0 1	>0	number		4	Q	121	•
-	171		30. Name and address of person 20874				Print) Tr	ruon 19 1	g Bac Execu	tive	Park T	erra	ace, Ge	rmantown,MD
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea		istrar's Signa	ature #	Space	Kr	/					

			For State Registrer	State of Mar		artment of H			iene	31812	
			1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month		3. Time of Death	
	Physici /Medio		BARBARA	Ρ.	RHODES			SEPTEMB			
}	Examin		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of Dea		
			Fort Washington		6 1 5 2 1	Fort Was	hington If Under 24 Hrs.		Prince (
	Funeral Director			6. Sex 7. Age (1 1 M 2⊠ F 57	In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)946 9. Bi	rthplace (State or Foreign Country)	
			238-76-4803 Usual Residence of Decedent					<u>October</u>	/ NO	rth Carolina	
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits	
	e Mar	ctor	MD PRINCE	GEORGE'S	FT. WAS	SHINGTON				1X Yes 2 □ No	
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	Country?	
	ath w	Funeral Director	11110 Costella				0744		U.S.A		
	er de Itama	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
36	irs aft	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		I□Yes 2√2 No	Specify:		Specify:	Black	
21215-0036	72 hours after death with the Maryland natural', or Itama 23a or 28a-1 show dical Eraciliser must be notified at		15. Decedent's	Education		tent's Usual Occupa			16b. Kind of Busines		
215	within 7 ene. than "n	ple	(Specify only highest Elementary/Secondary (0-12)	Grade completed) Coilege (1-4or 5+)	life. L	kind of work done of DO NOT use retired	during most of worki f)	ng			
21	e filed within al Hygiene. other then vent, tre Ma	Completed		5+	Soc	ial Worke	r		Governm	nent	
nd	be file	Be	17. Father's Name (First, Middle, L.	2 <i>st</i>)			18. Mother's Name	(First, Middle, A			
<u>Y</u> a	ould Men marke	²	Jobie Parker				Rosie		Black		
Maryland	12 shol		19a. Informant's Name/Relationshi	g (<i>Type, Print</i>) S Jr./Husband					City or Town, State,	<i>Zip Code)</i> Iaryland 2074	
	s 1 and 2 should be filed within 72 hours after death with the Manylan if Hauth and Mantal Hyglene. Itam 27 is marked othar than "netural", or Itama 23a or 28a-1 show other traumatic event, the Medical Eractic or must be notified at		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location - City o		
Baltimore,	0 0		1 XBurial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		-	natory`or other plac	1				
Ė	permit. Pag Depertment Important: h any injury o		21. Signature of Funeral Service Li		Roberson	I LIE Mem . Name and Addres			Robersonvi kins Funer		
ä	permit. Depertr Importe any inji		J. J. H	a should			J •		er, Maryla		
f	3 .		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused th						Approximate Interval Between	
Į,	Physician ¹		Immediate Cause (Final disease or condition	Sudden	CAPDIA	C DE	HTA			Onset and Death	
	/Medical		resulting in death)		consequence of):	^				an mount	
ŧ	Examiner		Sequentially list conditions.	ACUTE	COTONA	4 341	NOLOWE			ME KHOWH	
	sit ad	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c		Mi	1	- P.	h	UH KHOWN	
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c. Question. Due to (or as a c		UTE MY	1 DICAM MADIC	TNFA	ACTION	CH MOWN	
8760,	death certificate be axecuted e attending physician and d for use as the burial-transit			Question	able F	PULHON	ARY F	Mbolls	SM	LIN KHOWA	
687	ificate g phy-	edlcal		0, 1101							
Вох	eath certific attending p i for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [Ectopic pregnancy			23d. Date of de	elivery	
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		Other (specify)			Month	Day Year	
P.0	that the di ad by the detached	2hys	9 🗌 Unknown								
	S 50 00		Part II. Other significant condition		not resulting in the ur	nderlying cause give	en in Part I.			to the cause of death?	
Vital Records,	w require been si should	Completed by	• • • •	L (Δ.		1 ☐ Ye		Probably 4 Unknown	
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a	(0 -		HYPERTE	ision				perform		s 2 No	
Zit.	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
of	Phys	1: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury	at at		nce 6 Other (Spe w injury occurred	ecify)	
on	Attending F r death. actor: After by the funer	tlor	1 Natural 5 Pending 2 Accident investiga	(Month, Day Y	(ear) Injury	Work	(? Yes 2 □ No		ow injury occurred		
Division	I or Attendiater death. Diractor: A	ifica	3 Suicide 6 Could no	ot be 28e. Place of Injury	- At home, farm, stre	eet, factory, office	2	28f. Location (Str	reet and Number or R	lura I Route Number,	
Ö	s after al Dirac	Certification:	4 Homicide	building, etc. (<i>ъреспу)</i>			City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of r xeminer: On the basis of ex	ny knowledge, death	occurred at the tim	ne, date and place, a	and due to the ca	use(s) and manner a	s stated.	
	To the H within 24 To tha F complete	ledical	one)	and manner stated	d.						
	Vith To	Σ	29b. Signature and title of certifier	VALLE	IIM	29c. License		_	d. Date signed (Mon	in, Day, Year)	
7			Jamuel J	. Multon	ران		15656	2	41.571	04	
			30. Name and address of person 4				1	, .			
	Sta	te	Samuel Klein 31. Date filed (Month, Day, Year)	22 Registraria	Signaturo	stone Roa	ad Fort Wa	ashingto	n, Marylar	nd 20744	
	Registr		SEP 2 4 2004	Blace 1. K.	mark						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician 5:50AM September 20, Edith Marie Robertson 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours 1 □ M 2 🖾 F Yrs. 85 27, 1918 Michigan 579-10-7103 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiena. Important: or items 23a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Crofton MD Anne Arundel **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Rd. 21114 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 덮 No If Yes, Give 죠 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 H No Specify: Specify: ð 3

Widowed 4

Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Suzanna Hornyai Samuel J. Matyas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eve Hope Bender (daughter) 1743 Carry Pl., Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/04 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8 21. Signature of Fy 22. Name and Address of Facility Advent Funeral Services 42 Hudson St., Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Return Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly fillad in by the funeral director, page 2 should be datached for usa as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/2/Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and eddress of person who, completed cause of death (Item 23a) (Type, Print) 1655 Crofton Blvd., Crofton, MD 21114 Paul B. Berez, MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

32. Registrar's Signature

			State of Maryland / Dep	artment of Health and Me	ental Hygier	ne			
			1 - State Registrar C6	ertificate of Death	Reg.	No.004 31814			
	Physici		1. Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	3. Time of Death			
	/Medic		Anna Sanalitro Randall		_	23, 2004 8:30 p M			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	'	4c. County of Death			
	Funeral		St. Mary's Nursing Center 5. Social Security Number 6. Sex _ 7. Age (In yrs. last birthday	Leonardtown If Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	Saint Mary's 9. Birthplace (State or Foreign Country)			
	Director		579-07-6763 1□M 2 X F 95 Yrs.			1909 Italy			
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits			
	Maryla fied a	Į.		csville		1 ☐ Yes 2 No			
	death with the Maryland ims 23a or 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?			
	th with		39544 Jarrell Drive	20659	1	U.S.A.			
	after dea or Items	Funeral		. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	 Race - American Indian, Black, White, etc. 			
50	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yas 2 ♣ □ No If Yes, Give 3 2 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specity:		Specify: White			
215-0036	be filed within 72 hours after de tal Hygiene. d other than "natural", or Items event, the Medical Exercituer.		15 Decedent's Education 16a, Dec	edent's Usual Occupation	16b.	Kind of Business/Industry			
7	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)					
7	filed w Hygier ther th	Cor	8th Grade L. 17. Father's Name (First, Middle, Last)	P. Nurse	First Middle Maid	Medical			
yland	d be fi	Be c	Gaetano Sanalitro	Antonina		en Sumame)			
<u></u>	should nd Me mark	ဥ		ling Address (Street and Number or Rural F		y or Town, State, Zip Code)			
, Mar	and 2 alth a self tall			4 Jarrell Dr., Mech	anicsvil	le, MD 20659			
Baitimore,	of He of He if item		20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ Removal from State 20b. Place of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Dispos	position (Name of Pate Pate)	te 20c.	Location - City or Town, State			
Ē	tment tant: tant:		`4 □Donation 5 □Other (Specify) Brinsfie	eld - Echols 9-27-		harlotte Hall, MD			
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ODGs.			22. Name and Address of Facility Bri 22955 Hollywood Road					
	mada si		23a. Part1. Enter the divease, or complications that caused the death. Do not enshock, or heart failure. List only be cause on each line.	nter, the mode of ping, such as card at or	respiratory arrest,	Approximate			
	Physician		shock, or heart tailure. List on the cause on each line. Immediate Cause (Final disease or condition	al hiberation	G-0	Interval Between Onset and Death			
	/Medical		resulting in death) a. Due to (or a consequence of):	141		Municipal			
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	4 HNSRY 12		yrs			
	insit	miner	cause. Enter Underlying						
a î	te be executed ysician and se burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):	<i></i>					
2/60	ate be executed hysician and he burial-transit	Icai	d						
X Q	it the death certifica by the attending ph tached for use as the	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy						
žog	attend for us	slan/	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year			
o.	the de by the ached	nysic	1 Yes 2 No 9 Unknown 9 Unknown						
ď.	pa p	by PI	Part II. Other significant conditions contributing to gleath but not resulting in the	andenying cause given in Part I.	23e. Did tobacc	a. Did tobacco use contribute to the cause of death?			
Hecords,	w requires been signe should be		Lighteld of Elling		1 Yes	2 Mo 3 Probably 4 Unknown			
ပ္	law r nas be e 2 sh	Completed	Je stantion		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
			U /		performed?				
Vital	iysician: iis certifica director,	o Be	25. Was case referred to niledical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (6 □Other (Specify)			
0	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c Injury at 28	d. Describe how in				
Division	Attending F death. ctor: After y the funera	atlo	2 Accident investigation	M 1 Yes 2 No					
Š	or Attender de Directe	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28	f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier To Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, an	d due to the cause	(c) and manner as stated			
	e Hos 24 h e Fun letely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
)	Q,		amos avozi	D 06419		9-25-04			
4	8 2		30. Name and addr s of person who completed s e of death (Item 23a) (Type		1 16 "	1 00650			
	Sta	ate	31 Date filed (Molth Day Year) 39 Begist/ar's Signature	Notch Road Hollywood	d, Maryla	and 20650			
	Regist		SEP 2 8 2004 Day	good					

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Ragistra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Vaar MARY **Physician** DOLORES RYAN SEPTEMBER 20 2004 6: 30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Renaissance Garden at Riderwood Village Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, 1924 5 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 X F 80 Yrs. Colorado 217-28-8151 Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iner mat be notified at 1 Yes 2 XNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 3128 Gracefield Road, #111 20904 or Items 23e USA death w Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married ☐Yes 2 Yes, Give 2 🔀 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify traumetic event, the Mudical Example ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygiens Importent: If item 27 is marked other the eny injury og other traumetic event. 5+Federal Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George A. Ryan Mary Catherine McCarthy 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Broadwood Dr, Rockville, MD 20851 Mary Katherine Ryan Kapp/ 20a. Method of Disposition 20b. Place of Disposition (Name of September 23 20c. Location - City or Town, State Gate of He aven injury of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, Maryland Cemeterv 21. Signatur / of Funeral Service License 22. Name and Address of Facility Francis J. collins Funeral Home Inc. 50 University BLvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular accident **Physician** 3 WEEKS /Medical **Examiner** Asolration preumonia 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ. ed bluods 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 70 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 🗌 Yes death. 2 No 2 🗋 Accident after death Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Puthumana within 2 29d. Date signed (Month, Day, Year) 29c. License number D59524 SEPTEMBER 20,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEPIELD ROAD, SILVER SPRING, MARYLAND 20904 LOVEEN PUTHUMANA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State socks! SEP 23 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle Last) 3. Time of Death Day **Physician** September 29, 2004 9:37 a.m. Russello Forrest Barber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 37235 Lockes Crossing Road Mechanicsville St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Feb. 23, 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 ■ F Yrs. 574-46-5649 90 1914 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rthan "natural", or itams 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 € No Funeral Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37235 Lockes Crossing Road 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Pagas 1 and 2 should ba filed v tment of Health and Mental Hygie tant: If Item 27 is markad other t jury or othar traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ninion Barber Pauline Adams ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara D. Russello / Daughter 37235 Lockes Crossing Road, Mechanicsville, MD 2065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 Burial 2 □ Cremation 3 □ Removal from State permit. Paga Department of Important: If any Injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Eldon Grove Fam. Cem. 2, 2004 Mechanicsville, MD 22. Name and Address of Facility Brinsfield-Echols Funl. Hme., P.A. 21. Signature of Fundral Service Modds 2 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Stage Sequentially list conditions, if any, isaum to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cua to for as a consecuence of: Examiner sician and burial-transit The law requires that the death certificate be exacuted HTPS Due to (or as a consequence of) P.O. Box 68760, inding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day ō Month Year 4☐Pregnant at time of death 5 Other (specify) signad b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate To the Hospital or Atlending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.] 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 . 29.04 SAO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D., 22650 Cedar Lane Court, Leonardtown, MD 20650 31. Date filed (Month, Day, Year 32. Registrat's Signature 1 2004) 300000 State Registra

Division of Vital Records, P.O. Box 68760,

Antonio Reed September 28, 2004 O'53 F.	*	1 - For State Registrar 1. Decedent's Name (First, Middle	e, Last)		Certificate of	Deaiii	2. Date of Deat	h Day	Year	3. Time of Death								
Specially Numer (if not restriction; one street and number) 106.10-2 V111age Drive 23 'Yes, Morth Days Numer Number 10. See 10. County 10. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 108. See 100. County 100. Coly, Town or Location 109. See early Number 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 109. See 100. County 100. Coly, Town or Location 1			Mario A	Antonio	Reed			-		6:55 A								
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Paul Aloysius Reed Denise Ann Harris 19a. Informant's Name/Relationship (Type, Print) Denise Ann Hebb / Mother 20a. Method of Disposition 1 © Every and Service Ann Hebb / Mother 20b. Place of Desposition (Name of College Memorial Cardens) 1 © Every and Service Upcasses 1 © Every and Service Upcasses 21 Signatugify Furiesal Service Upcasses 22 Name and Address of Facility Matting lev-Gardiner Puneral Home, P.A. 1 P.O. Box 2/O Leonardtown, Maryland 20650 22 Name and Address of Facility Matting lev-Gardiner Puneral Home, P.A. 1 P.O. Box 2/O Leonardtown, Maryland 20650 Approximate strock or heart failure. Usin only one cause on each line. Due to (or as a consequence of): Due to (or as a consequen			Last)		Land	1	me (First, Middle, M			1116								
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State Registrar

DHMH 17 Rev 1/2001

2004

32. Registrar's Signature

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MINI 31. Date filed (Month, Day, Year)

ORIGINAL

9836 10/7/04 KRH Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend 17 per hosp. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev Year **Physician** 11,2004 September 0800 Baby Boy Smith /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore City Sinai Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number Hours 2 **Funeral** Deys 1**X** M 2 □ F Yrs September 11,2004 Maryland 30 Director Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. Stete permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depentment of Health end Mental Hygiene. Important: If Item 27 le marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 🗓 No Funeral Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21234 USA 8448 Oakleigh Rd. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant N/A 0 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virgil Bernard Robinson Rebecca Smith 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8448 Oakleigh Rd. Parkville, MD 21234 Rebecca Smith/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SIMAL HUSP 21. Signature of Funeral Service Licensee SIMAL HOST 240/W. BELVEDERE AVE ZILIS Henderson Dunn 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Ceuse (Final 2.5 hrs disease or condition resulting in death) a Severe prematurity Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician and I for usa as the bunal-transit or Attending Physician: Tha lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Be Completed by this certificate has been signered director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27 No Certification: To 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of fnjury (Month, Day Year) 1 Naturef
2 Accident 5 Pending e Hospital or Attending 24 hours after death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. the th 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of certifie September 11,2004 P17515 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Kimberly Walker, MD Sinai Hospital 2401 W. Belvedere Baltimore, MD 21215 Ave 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State OCT 07 2004

DHMH 16 Rev 6/95

Registrar

		1 - For State Registrar	State of	f Marylan		artmen rtificate					g. No.	004	31821	
Physici /Medi Examir	cal	Decedent's Name (First, Middle, Rosalie Virg 4a. Facility Name (If not institution, general contents)	inia Stro			4b. City,	Town, or	Location of	-	2. Date of Deat Month	Day	7 200°	7 10.46AM	
Funeral Director		Doctors Commun 5. Social Security Number 577–20–0902		tal 7. Age (In yrs. 86	last birthday) Yrs.	If Under Months		nham If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, 7/18/18	Year)	9. Bi	eorge's inhplace (State or Foreign Sountry) ingeburg, S.C.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event. If a Mudical Extrainer, must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County D.C. 10e. Street and Number 5304 James 11. Marital Status 15. Never Married 2 Marrier 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, La John Stroman 19a. Informant's Name/Relationship YVonne Couser/Ni 20a. Method of Disposition 1 \[\frac{1}{2}\] Burial 2 \[\] Cremation 3 4 \[\] Donation 5 \[\] Other (Specific Specific Specific Signature of Funeral Service Line Council Specific Signature of Funeral Service Line Council Specific Specific Signature of Funeral Service Line Council Specific	12. Was Dece Armed For I Yes I Yes, Giv Year or Da Education grade completed) College (1 st) O (Type, Print) CCE Removal from Scify)	12. Was Decedent Ever in U.S. Armed Forces? 1			Shington 10f. Zip Code 20019					10d. inside City Limit 1 Yes 2 N 10g. Citizen of What Country? U.S.A. or No- c.) 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry bor U.S. Government fiddle, Maiden Sumame) Govan Number, City or Town, State, Zip Code) ng, Md. 20903 20c. Location - City or Town, State Landover, Md.		
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, day leave to the final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (b. Due to (c. Due to (d. 23c. If yes, out 1 Live b 4 Pregn 9 Unknows contributing to de Hospital: 1 1 1 28a. Date (Mont) 1 28e. Place	or as a consequence of pregnatirh 2 Feta and at time of down or as a consequence of pregnatire of time 2 Feta and at time 2 Feta a	uence of): uence	DEctopic production of the sector of the sec	egnancy egity) A Othe Bac Injury Work 1 y work in my op	n in Part I. 26. Place of 4 \(\text{Nurs at at at and inion, death number} \)	of Death Sing Home	23e. Did tob 1	acco us s 2 □ (ed? No s) nce 6 w injury eet and State) use(s) a te and p	24b. Were a prior to death? 1 Yes Other (Specoccurred)	Day Year to the cause of death? trobably 4 Unknown utopsy findings available completion of cause of secify) tural Route Number,	
Sta Regist		30. Name and address of person was a second of the second	ern Sen 12. Ri	e of death (Item 5 '7; egistrar's Signa		Print) Q / /	51.	944 LAI	are!	m	20	2070	7	

DHMH 17 Rev 1/2001

Stroman, Rosalie

Willie Ray Sallie III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06014 State of Maryland / Department of Health and Mental Hygiene DOS 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Willie Roy Sallie, III September 18, 2004 0328 a^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forestville Prince Georges Pennsylvania Ave @ Forestville Rd. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F April 21, Director 579-08-3751 1984 Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show the Medical Examiner: part be notified at 1 Yes 2 □ No Maryland Prince George Forestville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 7600 Martha Street 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Items 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: Black ģ 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygient Importent: If item 27 le marked other the eny injury or other treumatic event. ITEL 2006. Food Preparer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Willie Roy Sallie, Jr. Michelle Whitle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michelle Sallie/Mother 7600 Martha St., Forestille, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/24/04 Clinton, Maryland 1 4 □ Donation 5 □ Other (Specify) Alexander S. Pope Funeral Homes 5538 Marlboro Pike, Forestville, 21. Signature of Funeral Service Licensee 20747 Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) luttole WILS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 🗌 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy death? 1 Yes performed? Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ DOther (Specify) at SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYes 2 □ No 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending neter Natural Pedestrian Struck 6, Vehic 281. Location (Street and Number or Aural Route Number, City or Town, State) Pennsylvania Neat Forestville Rd Forestville, MD 9/18/04 1 ☐ Yes 2 🗷 No 3:15 AM within 24 hours after death. To the Funerel Director: A investigation 2 Accident vehicle 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME: September 18, 2004 llauma 4 D cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 3 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State 2004 24 Registrar

			1 - For State Røgistrar	State of Mary		artmen rtificate			ind M	, ,	jiene] [31823
	Physici	20	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Ada Mae SHUPP							Septemb	7		4:40 p. ^M
4	Examir	er	4a. Fecility Name (If not institution, give str.			4b. City,		Location o			4c. County		
	Funeval		Coffman Nursing Ho 5. Social Security Number 6. Sex		yrs. last birthday)	If Under	1 Year	gerst If Under 2	24 Hrs.	8. Date of Birth	1	ningto	On lace (State or Foreign
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	with t	늅	800 Interval Road			10f. Zip		740			10g. Citizen of	what Cour	itry ?
	ns 23	by Funeral Director		Was Decedent Ever	in U.S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	USA 14. Rad	e - Americ	an Indian,
ပ္	or Her	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, spec 1 ☐ Yes 2			, Puèrto	Rican, etc.)		ck, White,	etc.
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Maryland	2 should I and Ment Is markar aumatic	-	19a. Informant's Name/Relationship (Type	Print)	19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	al Route Number	r, City or Town,	State, Zip	Code)
	rt 2		Gladys Gingery - s:					Lane,	Hag	gerstown	, Maryl	Land 2	21740
Baltimore,	0 0	1	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Rer		Ob. Place of Dispo cemetery, cre	matory or of	ther place)			20c. Location -	City or To	wn, State
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3alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	\mathcal{D}	/ /					NNICH F			
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Vital	ian: rtifica ctor, p	BeC	25. Was case referred to modical					26. Place	of Death	Check only on		103	20110
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Ē	ing Pl	ë.	27. Manne death 1 Platural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury		8c. Injury Work			28d. Describe ho	ow injury occur	red	
Sio	Attanding r death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		***	M		es 2 🗆 N	-	205 1			
Division	or At after of Dirac in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At nome, rarm, str pecify)	reet, factory,	, office		1	28f. Location (St City or Town		er or Hurai	Houte Number,
_	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one)	ian: To the best of my : On the basis of exa and manner stated.	r knowledge, deat mination and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, deat	place, a	and due to the ca	ause(s) and ma ate and place,	anner as sta	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1		29¢,	License	number		2	9d. Date signe	d (Month, L	Day, Year)
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	42		30 Name and address of person who com Samuel Chan, M	pleted cause of death $D 324$	(Item 23a) (Type, E. Antie	Print) tam	54.,	Hage	rst	own, M.	D 2174	40	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 7 2004	/32 Registrar's S	Signature	Les							

			For State Registrar	State of Marylan	-	artment of F rtificate of			ene g. No.2 () ()	31824
i i			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	
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	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		inhplace (State or Foreign Country)
	Director		214-30-1779	M 2LXF 72	113.			May 19,	1932 Pe	nnsylvania
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-	288-	ect	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What	Country?
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	na 23	Funeral Director		2. Was Decedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Sr	ecify Yes or No-		nencan Indian,
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	tal H d oth	Be	17. Father's Name (First, Middle, Last) James Ray Keefe	22				Beulah Ma		
<u> </u>	ould Men Narke Natic	은			10h Maili	na Addrass /Strant			City or Town, State	Zin Code)
Mari	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Typ						n, Md. 217	
ย์	1 and Healti em 2 ther 1		Richard W. Stevens 20a Method of Disposition	20b. I	Place of Dispo	osition (Name of		-	20c. Location - City	
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Баппо	it. Pg rtant njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 			2. Name and Addre	- 200		25 Bradbu	
מ	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or Itama 23a or 28a-f show important: If them 27 is marked other than "natural", or Itama as my injury or other traumatic event, the Modical Examinating the multified at once.		Zi. Signature of Pulletial Service Electrics						thsburg,M	
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			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.						Onset and Death
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	4	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
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Вох	eath certifi attending a	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
<u>п</u>	death he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of of 9☐Unknown	death 5	Other (specify)			Work	32,
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<u> </u>	The cate h	Sol						1 ☐ Yes	2 1 No 1 □ Y	
/ita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	logoital:		0*		ath (Check only on		
Ž	Physic this c	2	1 Yes 2 No		ER/Outpatie	int 3 DOA	4 Nursing F		ence 6 Other (S	pecify)
Ē	ing P	O.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?]Yes 2 □No	200. Describe III	ow injury occurred	
Division of Vital Records,	death.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome form of		1163 2	28f Location (St	treet and Number or	Rural Route Number,
<u>></u>	or At	Certification:	4 Homicide determined	building, etc. (Spec	ify)	ireel, lactory, office		City or Town		The distribution of
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 - Certifying Phys	sician: To the best of my kn	nowledge dea	th occurred at the t	ime, date and place	and due to the c	ause(s) and manner	as stated.
	Hos 24 ho Fun	Medical	(Check only 2 Medical Examination)	ner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	irred at the time, d	ate and place, and	due to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (M	onth, Day, Year)
	0		Duch of 1.	Milant	mi	0 0	41667		9.2	-7.04
10	AD.		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type	, Print)				
	3		Michael J.	Mc Cormed		110 N	redical	(know	Buson	low MP
	St	tate	31. Date filed (Month, Day, Year)	32. Tegistrar's Sign						
	Regis		SEP 2.8.200	14 Files	1. St.	rever				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Dav Year **Physician** 12:30PM 2PTZNO EN 20 3004 Helen Shorter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sep. 30, 1 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 69 1934 North Carolina Director 261-50-9181 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other then "naturel", or Items 23a or 28a-f show event, the Medical Examinat must be notified at Maryland Prince George Bowie MXYes 2 No Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 16010 Excalibur Road 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 f Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Enviromental Service Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willie Gilchrist, Sr. Eliza McPhatter 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is eny injury or other treu 2006. Henrietta Shorter/Daughter 2448 Corning Ave., #2, Ft. Washington, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 9/25/04 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signature of Funeral Service Licessee Alexander S. Pope Funeral Homes 5538 Marlboro Pike, Forestville, MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACRANTAL BLEED /Medical Due to (or as a consequence of) Examiner EREBRAL ATHEROSCLEROSTO Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has 2 No 1 ☐ Yes of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💀 No 2 1 🕿 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 \(\text{Homicide} \) within 24 hours a 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) ann, MD SEPTEMBEN, 2/12004 Shu 50862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHERIF HASSANIMD 9831 Greenbelt Road Suite 103 Lanham Md 20706 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2004

			. For	State of Ma		nd / Depa					-		_	•	
			1 - State Registrar			Cei	tificat	e of L	Death			Reg. No	.004	3	826
Н	Physici	an	Decedent's Name (First, Middle, Last,					6			2. Date of De Month	ath Da	y Yea	r	Time of Death
	/Medic	al	LAURA 4a. Facility Name (If not institution, give	street and number)			4h City		Location o		Septem		20, 200		1:55 ™
	Examin	er	THE JOHNS HOPKI		TAL	_			ORE		Y		, , , , , , ,		
	Funeral Director		5. Social Security Number 6. Se		e (In yrs.	last birthday)		1 Year Days	If Under Hours		8. Date of Bir (Month, Da 03/18/	th Iv. Year 1953	9. E	Birthplace (Country) W YOR	State or Foreign K
7	9		Usual Residence of Decedent											1	
	death with the Maryland ms 23a or 28a-f show Finust Let Letifical at	ă	10a. State 10b. County	.,		ity, Town or Lo	cation								side City Limits
	128a-	Directo	MARYLAND MONTGOMER 10e. Street and Number	1	ROC	KATUUE	10f. Zip	Code				10g. Ci	tizen of What	Country?	
	23a o zat be		14201 ALTA OAKS DR	IVE #203				2085	0			U.S	.A.		
	tems	Funerai		12. Was Decedent E Armed Forces?		J.S. 13.	Was Deced	dent of His	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.))-	14. Race - Al Black, W		tian,
1215-0036	be filed within 7/2 hours after death with the Marylan tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-1 show event, it a Medical Examinat must be notified at	by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🕅 N If Yes, Give Year or Dates:	10		1 🗌 Yes	2 ⊠ No	Specify:				Specify: V	HITE	
2-0	"natur	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	ient's Usua kind of wo DO NOT us	al Occupa rk done d	tion uring mos	t of worki	ng	16b. K	ind of Busine	ss/Industry	
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ם ק	e filed other vent,	BeC	17. Father's Name (First, Middle, Last)			1			18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
ylar	should be nd Menta marked imatic ev	ToE	ALBERT	RABINOW	ITZ				RHODA				NOVICK		
Maryland	2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Y S	19a. Informant's Name/Relationship (T)				-				I Route Numb				
	Health tem 27 other tr	1 3	GARY E. SEWELL/HUS 20a. Method of Disposition	BAND	20b. I	14∠U1 Place of Dispo cemetery, crer	the second second	more than the bank of			3, ROC		ocation - City		
ē,	Pages nat: # it		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			DEN OF				9/22	/2004	CLA	RKSBUR	G, MA	RYLAND
Baltimore,	permit. Pages Deportment of Important: If it any njury or one		21. Signature of Funeral Service Licens	Otati	me	222 DA	Name an NZANS 70 RO	d Addres KY-G CKVT	s of Facilit OLDBE LLE	RG M	EMORIA ROCKV	L CH	APELS,	INC.	
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	hysician	0	Immediate Cause (Final disease or condition	Beson	TC	toru	-	ilur						3 6	t and Death
	/Medical Examiner		resulting in death)	Due to (or sa	a consec	quence m:								-2	
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a										30	703=
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760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or 🐧 a	a consec	quence of):								0	
	# × #	dical		1.	_										
Box	leath certificat attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of			Tabania a						23d. Date of c	lelivery	
9 .	I he law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as tt	Physician/Med	in the past 12 months? 1 □ Yes 2 3 No 9 □ Unknown	4 Pregnant at 9 Unknown]Ectopic pr] Other <i>(sp</i>						Month	Day	Year
ა, ე	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions con	ntributing to death bu	ut not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did t		use contribute		
ord	w require been sig should b	eted									10'				4 Unknown
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Division	Ing Afte	ation	1 Natural 5 Pending investigation	(Month, Day	Year)	Injury	M	Work	?` ′es 2 □ I		cou. Describe i	iow irijui	y occurred		
	al or Att s after de il Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ıry - At h :. <i>(Speci</i> i	iome, farm, str fy)	eet, factory	, office		2	28f. Location (3 City or Tou			Rural Routi	e Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Medical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner sta	examina	owledge, death ation and/or inv	occurred estigation	at the tim in my op	e, date an	d place, a	and due to the ed at the time,	cause(s) date and	and manner d place, and d	as stated. ue to the ca	ause(s)
;	To the complete of the complet	Me	29b. Signature and title of certifier	AA 1.) /	` '	290	. License					te signed (Mo	-	
	4		Tracy f. Wans	uc, Medica	a / L	Joctor		Re	s - O	00		Sep	tembe	r 20	,2004
	1		30. Name and address of person who co							des .					
	Sta	te	Tracy Wanner, The Isl 31. Date filed (Month, Day, Year)	32. Begistre	ar's Signa	ature	000 N	orth	Wolfe	241	ect, Ba	Itim	ore, M	arylan	nd 21287
	Registr		SEP 2 3 200	4 Sine	مصر	19	Spa	reks	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ~22, Month **Physician** R. 7:15 PM September Rebecca 2004 Sinn /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3028 Patuxent Overlook Court Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)

Months Days Hours Min. Dec. 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 ☐ M 2X F 468-72-8236 49 Ĩ'954 Michigan Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show te petition ed tear 1 ☐ Yes 2 No Maryland Howard Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3028 Patuxent Overlook Court 21042 USA or Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:White þ 3 Widowed 4 Divorced naturel', al Hygiene. d other then "nature! event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, ITe 2008. Hotel Manager Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Carl Rugland Darlyne Mae Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christopher P. Sinn/husband 3028 Patuxent Overlook Ct. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W. Arundel Crematory 23, 2004 Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Lec. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LETASTATIC Physician BREAST 610 disease or condition resulting in death) /Medical Examiner INFLAMMATORY BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? į Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No ို 1 🗆 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 - Homicide within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MU September 23, 2004 e of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca KIMMEL CANCER CTR@HOPKING 4N70N11 OCEF 31. Date filed (Month, Day, Year) 32. Registra Signature State 4 2004 Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 23

32. Registrar's Signature

			1 - For State Registrar	State of M	larylar	•	artment of rtificate o			-	giene Reg. Ne	nn_b	31830
	Physici /Medic		1. Decedent's Name (First, Middle, MARY	Last)		SOLO	MON			2. Date of De Month SEPTEN	Da		3. Time of Death 2140 PM
7	Examin		4a. Facility Name (If not institution,				4b. City, Town	, or Location	of Death		4c.	County of Dea	th
			Shady Grove Adve			A A B A B A B	Rockvi		04 Hrs	0 D (D)		ontgome	
	Funeral Director		5. Social Security Number 337–38–4705	5. Sex 7. A 1□M 2ØF 8		last birthday) Yrs.	Months Day		Min.	8. Date of Bin (Month, Da ulv 5.	y, Year)	SWEC	thplace (State or Foreign ountry) 1en
	D		Usual Residence of Decedent		10- 6	- T				ury J,	191	J	Log to the Children
	n 72 hours after death with the Maryland "naturel", or liems 23a or 28a-f show adical Examinst must be notified at	tor	Maryland Montgom	nery	,	ty, Town or Lo	y Villa	ge					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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10	fter de	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Deceden Armed Forces d 1 ☐ Yes 2X If Yes, Give X	?		Was Decedent o If Yes, specify Co	ıban, Mexica	igin? (Spec n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
036	ours a		3X Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates	:		1□ Yes 2□ N	o Specify.	:			Specify: Wh	ite
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Maryland		P.	dolph Steiner			0				osenb1			
Mar	2 ga as 12		19a. Informant's Name/Relationship Louis Solomon/S			1	ng Address <i>(Str</i> e art Road						Zip Code)
re,	of Health item 27 other tr		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other p		Da	ate	20c. Lo	ocation - City or	Town, State
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Baltimore,	permit. Pages Department of It Importent: If ite any injury or of		21. Signature of Funeral Service Li	tensee	role		2. Name and Ado		SIM		ibut	e 1040	Rockville
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause nly one cause on each	ed the deal						rrest,		Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition		ute	dysn	hythn	na.					Onset and Death
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687	ificate g physi as the b	edic		d.									
Вох	eath certifica attending ph I for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pregnar	ncv				23d. Date of de	
.O.	The law requires that the death certificate be executed to has been signed by the attending physicien and to as should be detached for use as the burial-transit	Physician/Medical	in the past 12,months? 1 □ Yes = 2 ₺ No 9 □ Unknown	4□Pregnant 9□Unknown			Other (specify)					Month	Day Year
<u>α</u>	res that tigned by	by Ph	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	nderlying cause	given in Part	l.	23e. Did to	obacco i	use contribute to	o the cause of death?
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Records,	e law re has be	Completed		· · · · · · · · · · · · · · · · · · ·						24a. Was autop	osy	prior to	utopsy findings available completion of cause of
al F										1 ☑ Yes	rmed? 2 🗌 No	death?	20 No
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Division	in the	Certification;	3 Suicide 6 Could no 4 Homicide determin	28 e. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, st. fy)	reet, factory, offic	8	2	8f. Location (8 City or Tov			ural Route Number,
_	To the Hospital within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, as ath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 1	1/1/)	29c. Lice	nse number			29d. Da	te signed (Mont	th, Day, Year)
	2		MC	1/160	V V-		D	3884	+7	-	Sept	ember	6,2004
			30. Name and address of person w David N. Klein,				Print) ter Driv	re Rock	ville	e, MD	2085	50	
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa		Spork						
	Registi	rar	SEP 22 2	004		1	popula						

						•	Cei	tificate	of	Death		R	leg. No.	04 (3	831
	<u>-</u> ,		1. Decedent's Name (First, I	Middle, Las	st)							2. Date of Dee		Vass		e of Death
	Physici /Medi		Angel L. Sot	tomay	or							09	19	O4	3.	3004
}	Examir		4a. Facility Name (If not insti	itution, give	street and nu	ımber)			4	4b. City, To	wn, or Lo	cation of Death	4c. Count	ty of Death		
			Kensington	Nurs	ing & 1	Rehab.	Center	•		Kens	ingt	.on	Mon	tgomer	У	
Ī	_c Funeral		5. Social Security Number	6. S	ex/	7. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplac	ce (Sta	te or Foreign
	Director		580-34-9297	111	ØM 2□ F	6	7 Yrs.	WOTTERS	Days	110013	IVAICI.	Feb. 6,		Puerto	ό R:	ico
	p.		Usual Residence of Deceder													
	shov	_	10a. State 10b. Co	unity		10c. Cr	ty, Town or Lo	cation						100		e City Limits
	Ba-f	ç	Jersey	gen		Ri	ver Val								101	′es 2 x No
	it t	Director	10e. Street and Number					10f. Zip C	Code			1	0g. Citizen of	What Country	1?	
	ath w		210 Fondil	ler S					675				USA			
	tems	Funeral	11. Marital Status		Armed F		,S. 13. V	Vas Decede Yes, specif	nt of H y Cuba	lispanic Orig an, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - American ack, White, etc		,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by F	1 ☐ Never Married 2 ☑ 3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Gi Year or D	ve	1	√LYYes 2i	□No	Specify:	Puer	rto Rica		y: Whit		
Ģ	2 hot	Completed	15. Dec	edent's Ed	ucation		16e. Deced	ent's Usual	Occupa	ation			16b. Kind of E	Business/Indus	stry	
2	hin 7	ple	(Specify onfy h Elementary/Secondary (0-	-	de com <i>pleted)</i> College ((Give	kind of work OO NOT use	done d retired	during most d)	t of worki	ng				
2	d wit	E	12	,	College (1 401 517	Der	ntal I	ech	nicia	n		Dent	al Car	е	
	othe rent,	Be C	17. Father's Name (First, Mic	ddle, Last)						18. Mothe	r's Name	(First, Middle, M	Ma <i>iden Surn</i> ai	m <i>e)</i>		
Maryland	Ald by Jenta Ked Iic ev	ToE	Tadeo Soto	mayor						San	ntiag	ga Soto				
ary	shot Ind N Ima		19a. Informant's Name/Rela	tionship (7	ype, Print)		19b. Mailin	g Address (Street	end Numbe	er or Rura	l Route Number	; City or Town	, State, Zip C	ode)	
	alth alth 27 is		Olga C. Soto	mavor	/ Wife		210 1	ondil	ler	Stre	et.	River V	ale, N	J 0767	5	
e.	s 1 a f He item		20a. Method of Disposition	-		20b. F	Place of Disposemetery, crem	sition (Name	of er plec	(a)			20c. Location			
altimore,	Bag = 50		1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 🛣 Othe			State	ate of	Heave	n	/		-	ilver	Spring	. M	arvlan
Ħ	nit.		21. Signature of Funeral Ser	vice Licen	see		Cemet		Addres	ss of Facility	у _	uneral				
ä	Per la pe			1 .	0	000	1					wneral W, Sil			MD	20901
			23a. Part1. Enter the diseas	e, or comp	lications thet	caused the deat									pproxim	
	Physician		shock, or heart failure.	List only o	one clause on e	eech line.						,,	,	i In	terval E	Between nd Death
•	/Medical		Immediate Cause (Final			andi	0 0	206	. ~ ~	torn		0000	.+			
	Examiner		disease or condition resulting in death)		a	Dueto	0 - 20	Spi	, 0	100	7	UF LE	3 /			
		Jer				0001	B20 -	1/0		, Pa	1	Nice	2010			
	eath certificate be executed attending physician and I for use es the burial-transit	Examiner	Sequentially list conditions		b	Due to (c	or as a consequ	uence of):	<i></i>	4 (00	7	arre. dise	CIJE			
ó	ertificate be executed Jing physician and se es the burial-transi	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,		Rei									
68760,	te be ysicia	edical	that initiated events	1	c	-	r as a consequ									-
	tifica ig ph es th	led	resulting in death) Last		•	,		,						į		
ŏ	h cer endin	M/us			d				_				-			
o.	0 0	Physiciar	Part II. Other significent con	ditions co	ntributing to d	eath but not res	ulting in the un	derlving cau	se give	en in Part I.	-	23b. Did to	becco use co	ntribute to th	e ceus	e of deeth?
<u>о</u>	t the by th tache	چّ	00000	1001	- 6-	41.	60	- 0-		,	4.1.	1/2/Ye	s 2 No	3 Probab	dy 4	Unknown
	s tha	by F	Caran	my	O pa	ing	115	of a	m	DUI	apo	Deg.				
Records,	The law requires that the ate has been signed by the page 2 should be detache		12 8.9	2-0	P +	1 /		- 601	000	tone	0 .	24a. Was ar	autopsy	24b. Were	autops	
ပ္တ	s bee	Completed	- la Dule	13-	1001	1 17	per	1100	~ J.	JUE	وارودان	Periorii	led:	compl of dea	letion o	of cause
	he law te has age 2	E	DM	197	-1/	0	WD	Un	08	Kon	eyel	1 ∏Ye	s 2 No	1 🗆 Y	es 2	□No
Vital	sicien: Th certificate irector, pag	BeC	25. Was case referred to me	dical	,		1	-507		26. Plece	of Death	(Check only one			00 2	
5	ysicien: The l s certificate ha director, page	0	examiner? 1 ☐ Yes 2 ☐ No	-	Hospital:	Inpatient 2	ER/Outpetient	3□ DOA	Othe	/		ne 5 Reside	-	er (Specify)		
ō	Phy or this eral	-	27. Manner of Death		28a. Date	of Injury	28b. Time of		. Injury Work			8d. Describe ho				
<u></u>	tending leath.	z io	1⊿Natural 5 □ Pe 2 □ Accident inv	nding estigation	(MON	th, Day Year)	Injury	M		(? Yes 2.12√K	10					
Division of	Atter r des sctor by th	100		uld not be termined	28e. Place	of Injury - At he	me, farm, stre	et, factory, o	office		2	8f. Location (Str		per or Rural R	oute Ni	ımber,
	s efte	Certification:	4 🗀 Hoillidde		buildi	ng, etc. <i>(Specif</i>)	//					City or Town,	, State)			
	spita hours inere		29a. Certifier 12 Cert	ifying Phy	sicien: To the	best of my kno	wledge, death	occurred at	the tim	e, date and	place, e	nd due to the ca	use(s) and ma	anner es state	d.	
	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funerel Director: Atter this certifics completely filled in by the funeral director,	edical	(Check only 2 Medi	icai Exemi	ner: On the ba	asis of examination of stated.	tion and/or inve	estigation, in	my op	oinion, death	n occurre	d at the time, da	ite and place,	and due to the	3 cause)(S)
	withi To th	M	29b. Signature and title of cer	rtifier	11.	100	110			number			d. Date signe)
	- 2)		MIMM	X	1/W	X	MED.	\mathcal{D}	00	2553	362		09-	19-0	4	
7	30	-	30. Name and eddress of per	son who c	ompleted caus	e of death (Item	23a) (Type, F	ring)/R	INA	4 SERE	441	4.D K	aicer	Leoma	me	ate
			21018	asi	Jef	Person	151	lock	16	le 1	40	2085	2	,		
1	Sta	te	31. Date filed (Month, Day, Y	ear)	32. 7	egistrar's Signa	ture 🛵	1		_						
\$ 100 mg	Registr	ar .	JEP &	o CUL	14	- Park	10	apar	Ks							

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 23

sacked

Rockville, Md. 20850

Dr. Chitra Radagopal M.D. 9715 Medical Center Dr. #221

32. Registrar's Signature

			1 - For Stete Registrar	State o	f Marylaı		artment o			lental Hy	giene Reg. No.		3	33
	Di-		1. Decedent's Name (First, Middle	, Last)						2. Date of De			3. Time	of Death
	Physici /Media		Mary Madgelean Trav	'ers						Septembe:	Day r 18, 20	Year 004	7:30	0 A. M
	Examir		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, To	wn, or Locati	ion of Death		4c. Cou	unty of Death		
			45019 St. Luke Cour	't				Timbers			S	t. Mary'	S	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Under 1 \ Months D	rear If Un lays Hou	der 24 Hrs. rs Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birthp	lace (State	or Foreign
	Director		213~22~0657 Usual Residence of Decedent		80	Yrs.				October 4		Mary	.,	
	and and		10a. State 10b. County	.,	10c. C	ity, Town or Lo	cation					1	0d. Inside (City Limits
	f sho	ō	Managara I Grand	1										s 2 ∏No
	the 1	Director	Maryland St. Mar	y's	Ta	11 Timbe	10f. Zip Co	vde			10a Citizaa	of What Coun		
	with 3a or	Ö	45019 St. Luke Cour	•+			2069				-		itry r	
	hours after death with the Maryland tural; or Itams 23a or 28a-1 show al Exerciner fourt be notified at	by Funeral	11. Marital Status		edent Ever in U	J.S. 13.1		-	Origin? (Sp.	acify Yes or No-	US	SA Race - Americ	an Indian	
0	r Itar iner	Ę	1 Never Married 2 Marrie	Armed Fo	2 3 No		f Yes, specify	Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)	' ' '	Black, White,		
e e	Bal', o		3 X Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/e		1□Yes 2万	No Spec	city:		Spe	ecify: Blac	k	
ည	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar than "natural", or Itams 23a or 28a-f show avent. Ita Madical Exerciter must be notified at	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual C	ccupation			16b. Kind o	f Business/Ind	dustry	
2	filed within 72 Hygiene. other then "nel	pg.	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work of DO NOT use r	etired)	nost of work	ing				
21	filed wi Hygien othar th	Son	12			Homem	aker				Own I	Home		
ב	tal H d off	Be	17. Father's Name (First, Middle, L	.ast)				18. Mo	other's Name	e (First, Middle,	Maiden Sun	name)		
<u>X</u>	should be fand Mental I s marked of	ပ	George William Bris	coe					itie Ann					
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Si	reet and Nu	mber or Rura	al Route Numbe	r, City or To	wn, State, Zip	Code)	
	l and lealth m 27 har tr		JoAnn Nunley/Daught	er	100					imbers, M				
Baitimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e pnce.		20a. Method of Disposition 1 √x8urial 2 □ Cremation	3 □Removal from	State	Place of Dispo cemetery, cren	natory or other	r place)		Date lber 25,	20c. Locatio	on - City or To	wn, State	
<u>=</u>	tmen tant: jury		`4 Donation 5 Other (Sp	ecify)	St.	Mark's			200	4	Valley	Lee, Man	ryland	
a a	permit. Departr Imports any inju		21. Signature of Funeral Societ L	icensee		22 M	.Name and Aattingle	ddress of Fa	cility ner Fun	eral Home	. P.A.	P. O. F	30x 270)
	00 = e o		23a. Part1. Enter the disease, or o	Junar	1	L	eonardto	wn, Mar	yland 2	0650		1. 0. 1	JON 270	,
	/Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading 15 minutes are 15 minutes as 15 minutes a	a. Due to (nence (I):	Ru	nal i	FGil	me			Interval Bei Onset and	tween Death
.O. BOX 68/60	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unkno	irth 2 Feta ant at time of d own	ldeath 3□ leath 5□	Ectopic pregn Other (specif	y)				Date of deliver Month I	•	Year
Records, 1	sign d be	by	Part II. Other significant condition Stroke	is contributing to de	eath but not res	ulting in the ur	derlying cause	e given in Pa	rt I.		es 2 No	ontribute to the	e ca <i>u</i> se of c ubly 4 □l	
ည္က	law requ	Completed	Failm	· 107	Thriv		gast.	2254	וגומרי	24a. Was a	n 24t	o. Were autop	sy findings	available
	ician: The lar certificate has ector, page 2	E O	7 11				1		1	autops	ned?	prior to com death?	pletion of c	ause of
	sician: certifica irector, p	0	25. Was case referred to medical					26 PI:	ace of Death	(Check only on	2 No	1 Yes 2	2□ No	
>		0 0	1 Yes 2 No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatient	3□ DOA	O++		ne 5 Reside		ther (Specify)		
	ding Phys h. After this funeral di	=	27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time of		Injury at Work?		28d. Describe ho				
0	uttandin death. ctor: Af y the fur	atio	1		1, Day 16a)	Injury		1 ☐ Yes 2	□No					
DIVISION	af or Attanding s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 6 Could no determin	ned 286. Place	of Injury - At h	ome, farm, stre	eet, factory, off	ice	2	PBf. Location (St City or Town	reet and Nur 1, State)	mber or Rural	Route Num	ber,
	To the Hospital or Attano within 24 hours after deatl To tha Funaral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physicien: To the xaminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the estigation, in r	ne time, date ny opinion, d	and place, a leath occurre	and due to the ca	ause(s) and i	manner as sta e, and due to t	ted. the cause(s	i)
	To t To t	Σ	29b. Signature and title of certifier	-3			29c. Lic	ense numbe	36	2	9d. Date sign	ned (Month, D	ay, Year)	
•			16m71.	Buch	27, 12		1	0218	-43		9/2	7/04		
1	W.		30. Name and address of person w			п 23а) (Туре, Р					,,,,,			
-			Roy H. Bunales, MD,				gton Pai	ck, Mary	/1and 20	0653				
	Sta Registra	100	31. Date filed (Month Sep Year)	3 2004 32.	istrar's Signa	ture A	mel							

	1	State Registrar AMEND ITE		_			Tealth and Peath	Mental Hy	rgiene Reg. No 20	04 31834
Physicia /Medica	n	1. Decedent's Name (First, Middle, SARAH TONEY	Last)					2. Date of Do Month Septem	Day	3. Time of Death Year 2004 5:45pm M
Examine		4a. Fecility Name (If not institution, FOX CHASE NU				4b. City, Town, Silver	or Location of Deat		4c. County	of Deeth
Funeral Director		578-76-7096	5. Sex 1∭ M 2 (€) F	7. Age (In	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs	(Month, D	rth ay, Year) 5, 1915	9. Birthplece (State or Foreign Country) South Carolin
show dat	_	Usuel Residence of Decedent 10a. State 10b. County		100	City, Town or Lo		-,.			10d. Inside City Limits
a or 28a-f	Directo	D.C. 10e. Street and Number 445 Lamont S	t NW		wasiiiiigt	10f. Zip Code 2001	.0		10g. Citizen of W	
Important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow ery injury or other traumatic event, the Medical Examiner must be notified at QDGs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed F	2 XNo Sive		Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or Note Rican, etc.)		a - American Indian, k, White, etc. Black
The Medical B	Completed by	15. Decedent: (Specify only highest Elementary/Secondary (0-12) 6th grade	grade completed	(1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Bu	siness/Industry
c event,	To Be C	17. Father's Name (First, Middle, L Walter Benji						mə <i>(First, Middle</i> e Wilson	, Maiden Sumam	
raumati	ř	19a. Informant's Name/Relationsh	p (Type, Print)	ah+ au			and Number or R	ural Route Numb	er, City or Town,	
it: if item z. y or other i	-	20a. Method of Disposition 1 Durial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from	20	b. Place of Dispo	sition (Name of	Ave, N.W. Cemetery	Date	20c. Location -	City or Town, State
eny Injur ODCE.		21. Signature of Funeral Service L		do	22	2. Name and Addre	ess of Facility Jo	hnson &	Jenkins	Funeral Home
the bur	dical Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Resp Due to Due to	i each line. oirato: o (or as a cor onic Ol o (or as a cor	ry Failu:	re	ary Disea			Approximate Interval Batween Onset and Death
detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ☑No 9 □ Unknown		birth 2 🗍 gnant at time	Fetal death 3	Ectopic pregnand Other (specify) _	y		23d. Date Mor	e of delivery hth Day Year
peq .	2	Part II. Other significant condition	s contributing to	death but no	t resulting in the u	nderlying cause gr	ven in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
ector, page 2 should t	Completed							24a. Was auto perfe 1 Yes	psy pormed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
No.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 ER/Outpatier	nt 3 DOA	-	ath (Check only	one) idence 6 □Othe	or (Specify)
funera	27. Manner of Death 28a. Date of Injury Work? Month, Day Year) 1 Tree of Injury 28b. Time of Injury 28c. Injury at Work?								how injury occurre	ed
To the Funeral Director: completely filled in by the	Certifi	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Pla	ce of Injury - Iding, etc. (S)		eet, factory, office		28f. Location (City or To	(Street and Number wn, State)	er or Rural Route Number,
letely fil	edicai	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the	he best of my basis of exa inner stated.	knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
сотріві	Me	29b. Signature and title of certifier				29c. Licen		6		(Month, Day, Year)
(2)		30. Name and address of person via 8609 2NDAVENUE				Print) Usha	VenKata	rmo Gi	ollapa III	· MD
Stat Registra		31. Date filed (Month, Day, Year) SFP 2 4 20	20.	Registrar's S				1 A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0908 M Day Year Month Physician HOMP Mont 20 2004 non /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Dorchester ambilda orchester Creneral HUSPITO If Under 1 Year | If Under 24 Hrs. | B. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Sept. | 3, 19 7. Age (In yrs. last birthday) 48 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 12M 2□F 4-66-768 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at 1 ☐ Yes 2 No ambrida Dorchester Funeral Director MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō reek Road or Items 23a Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. 11. Marital Status th and Mental Hygiene. 27 is marked other than "natural", or Item traumetic event, the Modical Examinat 1 Never Married 2 Married Yes Cive 1 ☐ Yes 2 No Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION DRIVER 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked other. Sampson Mattie Thompson James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331-Church Creek Rd. Cambridge Md. 21613 20c. Location - Chy Town, State Jackie THOMP 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Cordtown emetery 25/04 Cambridg * 4 ☐ Donation 5 ☐ Other (Specify) 1-21 Name and Address of Facility 1 Home, P.A. 21. Signature of Funeral Service Licensee 510 washington St. Cambridge, MD, 21613 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician horr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit resulting in death) Last Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 \ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No Probably 4 □Unknown should ! 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

or Attending Physician: The law requires that the death certificate be executed Box 68760. O Division of Vital Records, P. within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral.

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

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2

31. Date filed (Month, Das Esp) 2

2004. Registar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Dorothy Marie Thompson September 21, 2004 1:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 21, 1928 | Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XXXF Yrs. Director 75 330-22-7076 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö Items 23a 90 Monroe Street #804 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 XWidowed 4 ☐ Divorced "natural" d other than "nature event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Associate Mental Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Stanley Michael Dunin Dolores Marie Bladen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i John Bladen Spaulding/son 106 Hamilton Avenue Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September permit. Pages Department of Importent: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 23, 2004 Odenton, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Bevelyz MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No icate has t 2 🗆 No 1 Yes 2 😾 No Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 Residence 6X Other (Specify HOSpice ē 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Hospitel or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42452 September 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chitra Rajagopal M.D. 1811 Prince Phillip Drive #327 Olney, MD 20832 30. Name and address of person 31. Date filed (Month, Day, 32. Fagistrar's Signature State Registrar

P.O. Box 68760,

Records,

Division of Vital

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		Sinai Hospital					Baltime	ore Cit	v		
Funeral Director			ox 7. Age XIM 2□F	(In yrs. lest bir	Yrs. If Un Monti	der 1 Year hs Days	If Under 24 Hrs Hours Mir 4 7	8. Date of Bir (Month, Da	th ly, Year)	9. Birthplace Country) 2004 M	(State or Foreign arylan
Pu .		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	n or Location						
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tha N	Director	Maryland 10e. Street end Number		Baltin		ity Zip Code		-	10a Citizan a	f What Country?	
with	٥	561 Bris Bane R	d							What Country !	
daath	Funeral	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was De	1229 cedent of H	lispanic Origin? (Specify Yes or No	USA - 14. Ra	ace - American In	dian,
permit. Pagas 1 and 2 should be filad within 72 hours after death with the Meryland Dapartment of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumetic event, the Medical Engineer must be notified at once.	Š	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:	0	If Yes, s	pecify Cuba s 2∏ No	an, Mexican, Puè Specity:	rto Rican, etc.)	Ві	ack, White, etc. ify: Black	ζ
72 ho	Be Completed	15. Decedent's Ed	ucation	16a.	Decedent's U	sual Occup	ation		16b. Kind of	Business/Industry	,
a. a. a. a. a. a. a. a. a. a. a. a. a. a	nple	(Specify only highest grad	College (1-4 or 5-	+)		work aone Tuse retired	during most of wo	orking			
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1 and 1aalti 1m 27	ļ	Keisha Williams	/Mother	56	ol Bri	s Ba	ne Rd.	Baltim	ore, M	ID 2122	9
gas Fire		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	cemeter	Disposition (I y, crematory o	or other plac	ce)	Date (20c. Location	- City or Town, S	state
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Dapar Import any ir		21. Signature of Funeral Service Licens Henderson Dum			22. Name	and Addre	ss of Facility	9-10-04 1 W. BE	ZVEDO	exe Ave	2/25
Physician /Medical Examiner	ler	Immediate Ceuse (Final disease or condition resulting in death)		re imm Due to (or es a c						Onsi	et and Death
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daath a atta id for	Scient	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlyin	n cause niv	en in Part I	23h Did	tohacco use c	ontribute to the	suce of death
ires thet tha daath cart signed by tha attandin d ba datechad for usa	y Phys		This could be death but	THO TO COUNTY III	The underlying	g cause giv	or iii ait i.		Yes 2 No		4 Unknow
raqu	Completed by Physician/M				-			24a. Was	an autopsy med?	available	on of cause
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Phys. this c	٦.	1 ☐ Yes 2 X No 27. Manner of Deeth	Hospital: 1 X Inpatien				4 La rearising r	Home 5 Resid			
Ilng f Thar Aftar funar	o	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		ime of njury M	28c. Injun Work		28d. Describe I	now injury occu	irred	
or Attending Physician: eftar daath. Director: Attar this cartific in by the funaral diractor,	ertificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, far (Specify)			Yes 2 □ No	28f. Location (S City or Tox		ber or Rural Rou	te Number,
To the Hospital or Attending Physician: Tha law within 24 hours efter death. To the Funeral Director: After this cartificate has a completaly filled in by the funeral director, page 2:	edical Certification:	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	eiclan: To the best of iner: On the basis of e and manner state	xamination and	, death occurre Vor investigati	ed at the timon, in my of	ne, date end place pinion, death occu	e, and due to the urred at the time,	cause(s) and m date end place	nanner as stated. , and due to the c	ause(s)
o the	Me A	29b. Signeture and title of certifier	and mariner state		2	29c. Licenso	number		29d. Date sign	ed (Month, Day,	Year)
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	-	30. Name end address of person who co	ompleted source of de-	ath (Item 22a) (Type Print	P175				ber 9,2	004
						Kimb	erly Wa	alker,M	D		
Sta	te	Sinai Hospital 31. Dete filed (Month, Day, Year)	32. Hegistrer	's Signature				ore, MD	21215		
Registr		OCT 0.7 20			5 A	port.	2				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1309 P **Physician** September 27 2004 Virginia Alice Wolf /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2XF 87 214-09-4357 Jan. 6, 1917 Virginia Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "nature" eny hinry or other treumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 No Funeral Director Hagerstown Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 920 Mt. Aetna Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 🛛 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: white Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Catherine Cullers Dock Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10906 Lincoln Ave., Hagerstown, Md. 21740 Barbara Resh - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/1/04 Hagerstown, Maryland Rose Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalue neral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Altrecordonotic cardio vos adan Discose Physician 5 years /Medical Due to (or as a consequence of) 2-saffcenn Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. be detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: Hospital or Attending 1. Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No death. Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D28365 9-27-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) null Street 368 Hagerstone MAD MANZAR 31. Date filed (Month, Day, Year) 3. Registrar's Signature State SEP 28 2004 Registrar

			1 - State Registrar	State of Mary		artment of H tificate of I			iene •g. No. () () ()	31840
	Physici /Medic		1. Decedent's Name (First, Middle, Last Catherine Jane	_				2. Date of Deat Month	Day Year	3. Time of Death p
	Examin		4a. Facility Name (If not institution, give Washington County				Location of Death	1	4c. County of Death	
	Funeral Director		217-00-3933	x 7. Age (li ☐ M 2🂢 F 83	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Feb. 23,	9. Birth 1921 Mai	nplace (State or Foreign untry) ryLand
	e Maryland Se-f show	ctor	Usual Residence of Decedent 10a, State 10b, County Md. Washin		Oc. City, Town or Lo	cation hsburg				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	ath with th	Funeral Director	10e. Street and Number 21804 Jefferson B	lvd.		10f. Zip Code	21783	1	0g. Citizen of What Cot	,
36	urs after dea II', or itams	by Fune	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 XNo	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: V	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Itams 23e or 28e-1 show any njury or other treumatic avent, the Madical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done of DO NOT use retired Homemaker	during most of wor f)	king	16b. Kind of Business/I	ndustry
Maryland 2	uld be filed Mental Hygie Irked other Itic avent, II	To Be Co	17. Father's Name (First, Middle, Last) John E. Loude	nslager			18. Mother's Nan	ne (First, Middle, M P. Baker		
	ind 2 sho alth and P 27 is ma or treums		19a. Informant's Name/Relationship (T) John J. Waltz Sr.						City or Town, State, Z r, $Md \cdot 2178$	
Baltimore,	Pages 1 and nent of Helent of the sent: If item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo	sition (Name of natory or other place	(Oct		20c. Location - City or 1 Smithsburg	Town, State
Balt	permit. Departi Import any nj		21. Signature of Funeral Service Licens	e Davis	.0 1-11-1	. Name and Addres			25 Bradbury thsburg,Md.	
	Pnysician /Medical		3a. Part1 Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the ne cause on each line.	1		g, such as cardiac		est,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Liter underlying Cause (Disease or injury	Due to (or as a co	inal	Failur	~			
,0928	cate be executed physician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of);					
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.		acco use contribute to	
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Division of Vital Records,	Attanding Physicien: Thr death. ector: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1	1 Ampatient 28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injun Worl	er: 4 ☐ Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Other (Speci	ify)
Divisi	of or Attsn after deat Director: d in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Str City or Town	reet a <i>nd Number or Rur</i> , State)	ral Route Number,
	To the Hospitel or Atten within 24 hours after deat yo the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy cone) 2 Medical Exami	sician: To the best of m ner: On the basis of ex and manner stated	amination and/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as site and place, and due t	stated. to the cause(s)
)	To the within 2	Me	29b. Signature and title of certifier Tuned MW	hed		29c. License		29	od. Date signed (Month,	
	6			RSHED A	~ 9	126 (pal Co	ent H	my Mel	21742
	Sta Registi		31. Date filed (Month, Day, Year) SEP 28 20	32. egistrar's	Signature #	este			1	

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2191. Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7.20 a M \bigcirc Z004 White Lorenzo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 59 7. Age (In yrs. last birthday) **Funeral** 1□XM 2□ F 1929 Washington, Director 20, D.C 74 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. If a Medical Event must be notified at 1XYes 2 □ No Maryland Prince Georges Ft. Washington Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20744 United States 510 Kisconko Turn Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1955-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black þ 3 Widowed 4 Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) School System Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary E. Benson Brooker T. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Kisconko Turn Ft. Washington, Md. 20747 Doris White / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State any injury o * 4 ☐ Donation 5 ☐ Other (Specify) Sept. 27, 2004 Cheltenham, Md. Marvland Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Š Pope Funeral Homes, Md. A. 20747 Alexander S. 23a. Part1. Erner the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner tany teacing to immuci cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🖸 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident I Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D52298 leted cause of leath (Item 23a) (Type, Print) DIVYA VER MA 30. Name and address of persing Greenway Ctp Drive #202. 1525 Green best MD 20770 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2004

wright, Leslie L.

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			For		State of Ma	arylan		•				ental Hy	giene		
			1 - Stata Registrar					Certifica	ite of	Death	-		Reg. No	(0)	31342
	Physicia /Medic		1. Decedent's Name (Fi	irst, Middle, Last Leslie) Liemore	e W	rigi	ht				2. Date of De Month	Day	79 Year	
	Examin		4a. Facility Name (If not		• (4b. Ci	y, Town, o	or Location	of Death	7		County of Dea	ath
			5. Social Security Numb	er 6. Se		SPI-	tal hal high	day) If Und	er 1 Year	AST of Under		9 Data of Bir	*10	17-6	Thplace (State or Foreign
	Funeral Director		218-20-9		M 2□F /. Ag		97 Yr	//			Min.	8. Date of Bir (Month, Da 10/31	y, Year)	L_ C	ruplace (State of Foreign ountry) yland
-	0		Usual Residence of Dec	cedent								10/31	700		<i>J</i> =
	arytar show	<u>_</u>	10a. State 100	b.County Caroli	7.0	10c. Cit	y, Town o	or Location		ъ					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
:	the M	Director	10e. Street and Number		пе			106	Zip Code	Pres	ton	····	10a Cit	izen of What C	
3	death with the Maryland ms 23a or 28a-f show rmust be notified at		4744 Pop		ck Road			101.		655				ted St	•
	ms 2	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.	S.	13. Was Dec			rigin? (Spec	cify Yes or No lican, etc.)		14. Race - Am	encan Indian,
21215-0036	ba tiled within 72 hours atter death with the Marylan Hygiene. I Hygiene. I dothar than "natural", or Itams 23a or 28a-f show avant, the Medical Examiner must be natified at	þ	1 Never Married		1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10		_	a∑k No			can, etc.)		Specify: W	hite
ָר ה	72 ho natur lical	eted		Decedent's Edu			16a. D	ecedent's Us	sual Occup	pation during mos	st of working	a _	16b. Ki	ind of Business	s/Industry
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Maryland	Shound N		19a. Informant's Name/	/Relationship (T	ype, Print)		19b. N	Mailing Addre	ss (Street					r Town, State,	Zip Code)
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Baltimore,	Pagas 1 sent of He int: If iter iry or oth		20a. Method of Disposit 1 Durial 2 □Cr		Removal from State	_ c	emetery,	crematory o	r other pla	· 1	Da			ocation - City o	
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g	permit. Pagas Department of I Important: If its any injury or o once.		21. Signature of Funera	of 1.	iskno			21. Name	and Addre	ass of Pacil	"Frai	nptom	Fur	neral	Home, P.A. MD 21632
			23a. Part1. Enter the d	isease, or comp	lications that caused	the deat	n. Do no							sburg,	Approximate
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	/Medical		resulting in death)		Due to (or as				10911	10 11	14/11/5	-0.70	, ,		www.
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20	ng ph ng ph s as th	Med	IF FEMALE:												
X Q	death certificate be attending physic d for use as the b	by Physiclan/Medic	23b. Was decedent pre in the past 12 mor	griain	23c. If yes, outcome	2 🗍 Feta	l death	3 Ectopic		у				23d. Date of de Month	elivery Day Year
o	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∏Pregnant at 9∏Unknown	time of d	eath	5 Other	specity) _						•
7	The law requires that the ite has been signed by thoage 2 should be detached.	y Ph	Part II. Dther significan	nt conditions co	ntributing to death be	ut not res	ulting in t	ne underlying	g cause gir	ven in Part	l.	23e. Did t	obacco u	ise contribute t	o the cause of death?
Records,	w requires that been signed to should be deta	ed b										1 🗆 🕆	Yes 2	□No 3□P	robably 4 Unknown
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		Com										perfo	rmed? 2 No	death?	. /
VITAI :	ysician: lis certifica director,	Be (25. Was case referred to examiner?	-	Utanaitale /						e of Death	(Check only o	ne)		
0	d is	. To	1 ☐ Yes 2 ☑ No 27. Mangfer of Death		Hospital: 1 Impatie		ER/Outp		JUA			e 5 Resid		6 Other (Spe	ecify)
0	th. : After fune	tlon		Pending investigation	(Month, Day	Year)	Inju		28c. Inju Wo	rk?]Yes 2[7G. D656/106 1	now injur	y occurred	
DIVISION	Atter er dea rector by the	Certification:		Could not be determined	28e. Place of Injubulding, etc	ury - At ho	me, farm	, street, fact	ory, office		28	If. Location (S City or Tox			lural Route Number,
5	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune			/											
	ne Hospital or Attending Pr n 24 hours after death. he Funeral Director: After th pletely filled in by the funeral	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	rsician: To the best of inar: On the basis of and manner sta	examina .	tion and/	or investigati	on, in my o	opinion, dea	ath occurred	at the time.	date and	place, and du	s stated. e to the cause(s)
:	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title	of certifier	ï			2	9c. Licens	se nu <i>m</i> ber			29d. Dat	e signed (Mon	th, Day, Year)
	-		•	John B	offis				\mathcal{D}	0059	487		9	127/0	4
			30. Name and address		and manner sta	eath (Item	1 23a) (Ty	(pe, Print)	СТ	Fail	and r	nd 2	160	1	
	Sta	to	Dr. John	Botsis	32. Registra	ar's Signa	ture	ry Ton	ЗТ.	ust	ore, I		,,,,,,	•	
	اد Registr		00		004	Aster .	3	Book	1						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Anderson October 2 2004 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University Medical Center of Maryland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEPT 29, 1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F 56 Director 213-46-2457 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28e-f ehow the Medical Examinar must be notified at Completed by Funeral Director 1 ☐ Yes 2 🔀 No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? lll Hollis Circle United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Material Handler Aerospace injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
eny injury or othar traumatic event Be James Earl Anderson Genevieve Onizuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Anderson/Wife 111 Hollis Circle, Elkton, Maryland 21921 20b. Place of Disposition (Name of Gilpin Manor Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State October 6, 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) 2004 Elkton, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee Š 1103 W. Stockton Street, Eikton, Maryland 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine I MeCords, P.O. Box 68760, C. The law requires that the death certificate be executed. for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lenkemia 1 Yes 2 No 3 Probably 4 Unknown Lymphocytic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? After this certificete 2 🗆 No 2 **V**No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury € 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funaral L TEC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) P18593 2004 M.D October Ulan Bundaranash 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bandaranayake Ci 22 South Illian Greene Baltimore 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RKI)		State of Maryland / Dea 1 - State Amend Item 10c&Unpend Item 23a_2	artment of Health and No. 1 28a-1 per me G83	•	_	2101.1.
		75.	Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici		Ronald Gregory Ayres, Sr.		Month OCTOBER	Day Year 4,2004	12:20P. M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
			2710 McCOMAS ROAD	DUNDALK		BALTIMORE	<u> </u>
707	Funeral Director		5. Social Security Number 217-60-3454 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 03/09/	9. Birth <i>Cou</i> 1955 Mar	place (State or Foreign intry) Yland
~	/land		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show froust be rutified at	ctor	MD Baltimore 2710 McC	Comas Avenue Dur	da1k		1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Cou	intry?
	s 23a	ral	2710 Mc Comas Avenue	21222		U.S.A.	
	after dea or Itams	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White	
920	urs at	by §	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh.	ite
21215-0036	72 hours after natural', or Ita	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	rina	16b. Kind of Business/Ir	ndustry
21	within ene. than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)			
2	illed v Hygie thar t	Co	9 Mec	chanic 18. Mother's Nam	e (First, Middle, N	<u> Leavy Machi</u>	nery Ind.
ano	d be ental kad o	To Be	Norman Lee Ayres		ia Ann Ba		
Maryland	shoul	F		ing Address (Street and Number or Rui			o Code)
	and 2 alth a 127 Is		Patricia Ann Guldan (mother) 110	35 Pulaski Highwa	y - White	e Marsh, Ma	ryland 2116
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If itam 27 Is markad othar than "natural", or Itams any injury or othar traumatic evant, It's Modical Externities force.		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposemetery, cre	matory or other place)		20c. Location - City or T	
Ĕ	Pag ment ant: I		`4 □Donation 5 □Other (Specify) Oak Lawr			Baltimore,	
3alt	permit. Depart Import any in		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility E_ullet	F. Lassa	ahn Funeral	Home, P.A.
68760,	Amount certificate be executed with the state of the stat	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to him additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Probable Self-Admit Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		. ,		Approximate Interval Between Onset and Death
P.O. Box 6	Attanding Physician: The law requires that the death certifica r death. r death. actor: Atter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
Division of Vital Records, P	uires that n signed b lid be deta		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		accoluse contribute to to	
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Re	The lay	mo			autopsy perform	ed? death?	mpletion of cause of 2☐ No
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× <	Physic this ce al dire	ဥ	Y Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			nce 6 NOther (Specif	V)SCENE
o uc	ding P	lon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury Found, Day Year) 10-4-2004 28b. Time of Found, Day Year)	Work?	28d. Describe hov	v injury occurred	
Sic	ttandi death. ctor: A y the fu	icat	3 V Suicide 6 Could not be Ose Bless of laive. At home form at	-	Unknown 28f Location (Stre	eet and Number or Rura	of Route Number
Div	after Dirac	Certification;	4 Homicide determined building, etc. (Specify) Scene		City or Town, Dundalk,	State)2710 McC	omas Road
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place,	and due to the cau	use(s) and manner as s	tated. the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
			> quest	O.C.M.E.	∞	TOBER 5,20	04
u-	17		30. Name and address of person who completed cause of death (Item 23a) (Type, AMA RUBIO, MD	Print) 111 Penn Street, I			
	Sta Registr	- 60.0	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sparks			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Month **Physician** 6:15 a м OCT 2004 LEONA J. BRANNAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 603 S. ANN STREET 217 APT. BALTIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 8/8/12 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🔀 F MARYLAND Director 212-03-4640 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28e-f show treumatic event, the Medical Exercit er toust be notified at 1 Yes 2 □ No Completed by Funeral Director BALTIMORE N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 21231 USA or items 23s 603 S. ANN STREET APT. 217 Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other than "neturei", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSEKEEPER ST. PATRICK'S CH. 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALICE MROZ LEOPOLD JACKEWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R SPRING, MD. 20c. Location - City or Town, State 612 FIELDSTONE RD. SILVER MRS. DIERDRE BOND other t Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department o Importent: if any injury or once. MEADOWRIDGE MEM.PK. 10/8/04 ELKRIDGE, MD. 21. Signature of Funeral Service KACZOROWSKTacFUNERAL HOME P.A. Carto 2525 FLEET ST. BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final per tene in Physician disease or condition resulting in death) /Medical (or as a consequence of) Due to Examiner aemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit Osteown.t. that initiated events The law requires that the death certificate be execuresulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 0 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a Was an autopsy 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Certification: Injury 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00055171 6/01 30. Name and address of person who completed cause of death (Item 279) (Type, Print)

3023 Faltern Arenne, 15dt more MO 21224 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State DCT 0 8 2004 Registrar

			For State Registrar		ryland / D	epartment of F Certificate of	lealth and M	Mental Hygid	_	. 9191.6
	o Physici /Medio		Decedent's Name (First, Middle, La OMEGA	est) MA	В	BLOOM	1	2. Date of Death Month October		3. Time of Death Year 004 12:12 P ^M
	Examir		4a. Facility Name (If not institution, gi		-7 Com		r Location of Death		4c. County of	Death Harford
	Funeral		, , , , , , , , , , , , , , , , , , , ,		(In yrs. last birti		Bel Air If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	/ear)	Birthplace (State or Foreign Country)
	Director		214-42-1479 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town			9/8/19	44 1	Pennsylvania 10d. Inside City Limits
	Maryla -f shov	tor	MD. Hari	ord	Too. City, Town	or Education	Forest	Hill		1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Code			g. Citizen of Wh	
	ns 23a	Funeral	2090 Brandy 11. Marital Status	Drive 12. Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba	21050 lispanic Origin? (Sp		14. Race	States - American Indian,
920	should be filed within 72 hours after death with the Maryland nd Mental Hygene. marked other than "naturel", or Items 23a or 28a-f show marked other than "naturel", or Items 23a or 28a-f show marked other than "natice event, the Madical Engine or must be notified at	à	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes 2 💥 No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, etc. White
Maryland 21215-0036	"natur	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	ring	6b. Kind of Bus	iness/Industry
212	d withir giene. or than	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Close			Mortga	ge Banking
and	be file tal Hy od othe event,	Be	17. Father's Name (First, Middle, Las	1)		Hahn		e (First, Middle, Ma		
ž	should nd Mer marke imatic	ဥ	John 19a. Informant's Name/Relationship	(Type, Print)			Naom and Number or Run		lice City or Town, Si	Ahalt tate, Zip Code)27265
	and 2 saith ar n 27 is		Tonia R. Hunt/	Daughter	15	20 Birkda	le Ct.	High .	Point.	N. Carolina
ore	tges 1 nt of He : If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			Disposition (Name of r, crematory or other place				tity or Town, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked ery injury or other treumatic a <u>once</u> .		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	A t	Carro	22. Name and Address				ead, Maryland Maryland
m	Depa Impo eny is		11. Blevele	len Tur	13-11-	E.G. Ku	rts & S	on Fune:	ral Ho	me, P.A.
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line	nerdeath. Do n	ria with	Pulman	or respiratory arres	i,	Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)		consequence		, , ,		(1)	3 days.
760, 5	s be executed sician and s burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate the leading to immediate the leading to impediate the leading to the leading that initiated events resulting in death) Last	c	consequence o					
P.O. Box 687	ath certifica ttending ph or use as tl	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date Month	<u> </u>
	uires that the de signed by the a Id be detached f	by Pt	Part II. Other significant conditions	-	_	the underlying cause give	en in Part I.			tute to the cause of death?
örd	w require been si should I	eted	Smull Bowe		Croa.			1 ∐ Yes 24a. Was an	2 □ No 3	
Vital Records,	sicien: The law certificate has t irector, page 2 s	Completed	Sepsis Sy. Supra yent 25. Was case referred to medical	icular Ta	chy ca	rdin.		autopsy performe	d? prid	ere autopsy findings available or to completion of cause of ath? Yes 2 No
<u> </u>	ysicien s certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Out			h <i>(Check only one)</i> ome 5 ☐ Residenc	ce 6 ☐Other	(Specify)
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. T	me of 28c. Injury	y at	28d. Describe how		
Divis	after death after death Director: d in by the	Certification:	3 Suicide 6 Could not determined			m, street, factory, office		28f. Location (Stree City or Town, S		or Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best o miner: On the basis of and manner stat	examination and	death occurred at the tin /or investigation, in my o	ne, date and place, pinion, death occurr	and due to the caustred at the time, date	se(s) and manr and place, and	ner as stated. d due to the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier	11.16		29c. Licenso	9 number			Month, Day, Year)
	6		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print) 2 North	K Ave.			nd. 21014.
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	h 1				
DHI	MH 17 Rev 1/2			104 June		spar.				
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Bloom, Omega

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep	artment of Health and Nartificate of Death	lental Hygie Reg.	2001 21017
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death 5:20 PM
	/Medic Examir		4a. Facility Name (If not institution, give street and number) AAMC	4b. City, Town, or Location of Death		4c. County of Death Sure Averal
	Funeral Director		5. Social Security Number $130-16-5419$ 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last birthday 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 5, 19	ar) 9. Birthplace (State or Foreign Country) New York
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or L MD Prince George's Glenn D			10d. Inside City Limits 1 ∐ Yes 2 🛣 No
	th with the 23a or 28 all be no	Funeral Director	10e. Street and Number 10607 Forestgate Place	10f. Zip Code 20769	10g.	Citizen of What Country? USA
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23a or 28a-f show other treumetic event, the Medical Evarinar must be rotified at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho lene. Then "netur The Medical I	Completed	(Specify only highest grade completed) (Givilife. Elementary/Secondary (0-12) College (1-4or 5+)	odent's Usual Occupation e kind of work done during most of work DO NOT use retired) Homemaker	ing	. Kind of Business/Industry
Maryland 2	should be filed and Mental Hygis marked other umetic event, II	To Be Co	17. Father's Name (First, Middle, Last) Axel Lanquist		e (First, Middle, Maid	
	ind 2 sho alth and 1 27 Is ma or treume			ing Address <i>(Street and Number or Aur</i> 7 Forestgate Place		
Baltimore,	8 2 2 5		1 Li Buriai 2 Ly Cremation 3 Li Hemovai from State	osition (Name of matory or other place) itan Crem. 10-5-		Location - City or Town, State
Balti	permit. Pa Departmer Important: eny injury			^{2. Name and Address of Facility} Be 512 NW Crain Highw	all Funera ay Bowie	al Home e, MD. 20715
	The law requires that the death certificate be executed to the stending physician and sage 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
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rds, P.	w requires that t been signed by should be detar	þ	Part II. Other significent conditions contributing to death but not resulting in the of Denue of Contributions and Contributions are supported by the conditio	underlying cause given in Part I.		o use contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performed 1 ☐ Yes 21	24b. Were autopsy findings available prior to completion of cause of death? 1
of Vital	N S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho		6 □Other (Specify)
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier MD	29c. License number 55 8510		Date signed (Month, Day, Year)
•	1		30. Name and address of person who completed cause of death (Item 23a) (Type Stephen Olexo AAWC			(-/-
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 8 2004 32. Registrar's Signature	Soork		

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Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
/Med	ical	Thelma Caroline Brosius 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	30, 2004 4:45A ^M
Exam	iner	93 Church Road	Arnold		Anne Arundel
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreig. Country) Pennsylvania
Director		213-38-7609 93 113. Usual Residence of Decedent		1/2/1911	Pennsýlvania
Aarylan f show	or	10a. State 10b. County 10c. City, Town or Anne Arundel Arnold	Location		10d. Inside City Limits 1 ☐ Yes 2X No
ith the h or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
sath w	ia	93 Church Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	21012	noite Van as Na	U.S.A.
II 21213-UU30 Iffled within 72 hours after death with the Maryland Hyglene. Ther then "natural", or items 23e or 28e-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② ◯ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Pican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72 hours "natural",		15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	16b.	Kind of Business/Industry
121 within 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 O Homer	DO NOT use retired)		n home
d a la b ≥	Be	17. Father's Name (First, Middle, Last) William J. Sell		(First, Middle, Maide	
Baltimore, Maryla bermit. Pages 1 end 2 should Department of Health and Men Important: If tem 27 is marke my nibury or other treumatic. once.	To		ling Address (Street and Number or Rure Church Road, Arnolo		
of Hear		20a. Method of Disposition 20b. Place of Disposition cemetery, cr	position (Name of pematory or other place)	Pate 20c.	Location - City or Town, State
Page ment tant: If			Church Cemet. 10/5/		ntain Springs, PA
Dall permit Depar Impor		21. Signature of Funeral Service Licensee	22. Name and Address of Facility farring—Cargo Funer Aberdeen, Maryland	al Home, 1 21001-33	P.A. 99
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requirement of the law reached law	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	DEMENTIA		Interval Between Onset and Death
P.O. BOX 63 nat the death certific d by the attending p letached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, P		Part II. Other significant conditions contributing to death but not resulting in the	,···3	23e. Did tobacco	use contribute to the cause of death?
cord w require been si	ted	CEREBROVASCULAR DISEAS	<u> </u>	1 🗆 Yes	2 No 3 Probably 4 Unknown
The law	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital F	Be	25. Was case referred to medical examiner? 1. Type 2. Set No. Hospital: 1	26. Place of Death		
Vision of Vita Attanding Physician: r death. sector: After this certifici	on: To	1 ☐ Yes 2 KNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 1 ☐ Matural 5 ☐ Pending 1 ☐ Month, Day Year) 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 1 ☐ Injury	of 28c. Injury at Work?	ne 5 Residence 28d. Describe how inj	6 ☐ Other (Specify) ury occurred
5 th 5 c	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Hospita 4 hours Funeral ely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dead one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurred	and due to the cause(ed at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
To the I within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number		rate signed (Month, Day, Year)
		30. Name and address of perion who completed cause of death (Item 23a) (Type	D57531	SEI	Prember 30, 2004
8		Mohit Nego BGOI Veterans	Muy Millers	ville, n	10 21168
St Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's-Signature			

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6, 2004 **Physician** NORMAN BOWEN SR. Η. 11:15 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 339 Cambridge Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 14,1934 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Yrs. 213-30-5262 70 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rail, or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 339 Cambridge Road 21122 permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. I importent: if I fem 27 is marked other than "naturat; or Items 23 any injury or other traumatic event, II:a Madical Examiner must any injury or other traumatic event, II:a Madical Examiner must ence. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Marned 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Stone Mason Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Earl G. Enos Pauline Orem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norene E. Bowen (Wife) 339 Cambridge Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cem 10-11-04 21. Signature of Funeral Service Licen 22. Name and Address of Facility cCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 a. Denti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician /Medical **Examiner** Spuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhilated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed after death. Due to (or as a consequence of): physician a the burial-1 Box 68760, Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Přobably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas certificate ha 2 No 1 ☐ Yes uneral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:.

completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 📿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ြ rm.B 10-7-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ζχ\ mountain Rd. Pasadera, mualias dc Bor a 3 3708 31. Date filed (Month, Day, Year) State Registrar OCT 0 8 2004

				State of Ma	nuland / l	k Indelible Ink. Department of F	loolth and	_		-	
			1 - For State amend item 11 per Registrar	exwife g83	9 1/31/0	Certificate of	Death	inona in	Reg. No	10° m 10° m	DIDEO
	Physici /Media		1. Decedent's Name (First, Middle, Last) DERRICK	LAMON	+	Brice		2. Date of De Month		() () -	3. Time of Death
	Examir	er	4a Facility Name (If not institution, give s	treet and number)	+0	4b. City, Town, o	1		4c.	County of Death	NA
ı	Funeral Director		Social Security Number 6. Sex	-/-	e (In yrs. last bi	rthday) If Under 1 Year Months Days	MOR 9 If Under 24 H Hours Mi	rs. 8. Date of Bir	rth ay, Year) 959	9. Birth Cou Mary	place (State or Foreign
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					10d. Inside City Limits
	Maryl a-f ehc	tor	MD NA			Baltimore					1X Yes 2 ☐ No
	vith the	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	untry?
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036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f ehow event. It a Midical Examinar rust be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced	Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White Specify: Bla	, etc.
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ylaı	should be and Mental marked o	70	Edward Hamilton				ah Murel				
Mar	2 2 2 2		19a. Informant's Name/Relationship (Type Patricia A. Parker/ Fri	-		5. Mailing Address <i>(Street</i> 507 Edmondson A					ip Code)
	s 1 and 3 if Health litem 27 other tra		20a. Method of Disposition		20b. Place of	of Disposition (Name of ary, crematory or other pla		Date		ocation - City or 1	Town, State
altimore,	Pages ment of 1 ant: If its ury or o		1X Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	1	n Forest Vetera		13-2004	Owi	ngs Mills,	MD
Ball	permit. Pages Department of a Important: If its any injury or o		21. Signatur, Funeral Serve License	make	1	22. Name and Addre	-	8 N. Gilmon	r St.	Balto, MI	21217
68/60,	Physician //Medical Examiner physician and physician and physician and physician site physician site physician and physician site physician and physician an	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as		of):					Interval Between Onset and Death
C. BOX	ithe death certificate by the attending physicached for use as the b	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	n 3□Ectopic pregnanc 5□ Other (specify)	у			23d. Date of deli Month	very Day Year
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VItal	eiclan: certifica rector, p	BeC	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes Death (Check only		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20110
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0	Attending Phyer death. Foctor: After this by the funeral di	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury Wo	rk? Yes 2 □ No	200. 0630/100	110** 11130	y occurred	
DIVISION		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubil	ury - At home, f c. (Specify)	arm, street, factory, office		28f. Location City or To			ral Route Number,
	To the Hoepital or within 24 hours afte To the Funeral Dir completely filled in	edicai (29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of er: On the basis of and manner sta	of my knowledg examination a sted.	e, death occurred at the ti nd/or investigation, in my o	me, date and pla opinion, death or	ace, and due to the courred at the time	cause(s , date an) and manner as d place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	moun		29c. Licens	se number	K14443	29d. Da	te signed (Montil	7, 2004
j	111		30. Name and address of person who co SCOTT KATZEN, M	mpleted cause of d	eath (Item 23a)	(Type, Print) NG-R	ene Sta	cet BAL	timu.	ee MD o	2/20/
	Sta Registr	-	29b. Signature and title of certifying Physical Examination one) 29b. Signature and title of certifier 30. Name and address of person who concern the concern of the conc	3 Registra	ar's Signature	Goods					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month AM **Physician** OCTOBER & HOWARD LAZAL 1:15 4006 2 Wis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Inder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) BALTIMORE FRANKLIN WOODS 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 190M 2□F Months Yrs. 214-18-8024 83 Director JAN. 19 1921 Usual Residence of Decedent iled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be intilified at 1 ☐ Yes 2X No MARKAM BALTIMORE **Funeral Director** 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number A.Z.U 21934 Troin Godf VSAUS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 28 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 🏖 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 705 25/181 TRANSPORTATION ANALYSIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be be f and Mental BLAND ZWis H LORETTA SIYMOUR 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 1. KATH1221 20c. Location - City or Town, State NH HOUND ROJE 20b. Place of Disposition (Name of OCT S 20a. Method of Disposition cemetery, crematory or other place) 1器 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. injury or MARKVILLE Donation 5 Other (Specify) 4006 Berenz native of Funeral Service Licensed 22. Name and Address of Facility MLMS RILLS 21. Sik SSCO HUSTELL TOURS LHICKNING JACITHO 3594 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compli ration: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Unnour La /Medical Due to (or as a consequence of): Examiner Due to (or as consequence of): OCOCCUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy lor Month Day Year 5 Other (specify) detached ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ fa 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an demention page 2 autopsy performed? certificate 1 Yes the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b Time of or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide within 24 hours a To the Funerel C Medicai 29a. Certifier 📧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified M como do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1109105 Franklin demondson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician William T. Coxon October 4, 2004 10:04 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. 204 South Woodwell Road Dundalk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Yrs Director 26,1922 Maryland 215-14-0636 81 Oct. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, u.e.M. diculexa cirer must be notified at 1 Yes 2 No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 204 South Woodwell Road Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: If Yes, Give Year or Dates: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Union Local 37 Oiler Operator 7 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental F pe Anna Kessler John Frances Coxon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Mrs. Julia S. Coxon / Wife 204 South Woodwell Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/7/2004 Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Interval Between and Death Immediate Cause (Final vonau Physician disease or condition resulting in death) /Medical of): (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-transif Due to (or as a consequence of) ng physician a as the burial Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1 Yes 2 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) Director: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division Injury Attending 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 e Hospital of 24 hours af pellil teritying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. the within To the the 29d, Date signed (Month, Day, Year 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 6730 Holabird Ave. Ali Sanai, M.D. 21222 Baltimore, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 8 2004 Registrar

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e, K	Ith ar Ith ar 27 Is r treu		19a Informant's Name/Relationship Rebecca Cessna	wife		^{19b. Mailir}	g Address (Street Cessna L	and Number or I -ane	Rural Route Numb Cleai	er, City or To Ville	own, State, Zin	1553	5
	of Herrorth	0.000	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		Pro	Place of Dispo emetery, crep sperity C	sition (Name of patory or other place emetery	ce)	Date 10/5/2004		ion - City or To Stone		i D
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SIO	tending death. tor: After the funer	catlo	1 □ Natural 5 □ Pending 2 ■ Accident investigati 3 □ Suicide 6 □ Could not	on 9130104	į.	11:14 F	M 1□	Yes 2. No		EJECTED DRIVER OF CAR			
DIVISION	e hospine or Areanding Priysican: 2 Hours after death, 8 Funeral Director: After this certificately filled in by the funeral director, i	Certification;	4 Homicide determine		ry - At ho . (Specify	ome, farm, stre	eet, factory, office		28f. Location (: City or Tou KNOBLEY	Street and Nu vn. State) ROS Hu	ORT GA	I Route Numb P CナーV に足い	
	e nospital 24 hours a e Funerel letely filled	edical	29a. Certifier 1 ☐ Certifying I (Check only one) 2 ☑ Medical Ex-	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at the tire estigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	l manner as st ce, and due to	ated. the cause(s)	
	within 2.	Me	29b. Signature and title of certifier				29c. Licens				gned (Month,		
			▶ anetz					C.M.E.		Octobe	er 02,	2004	
	lo		30. Name and address of person wh	o completed cause of de	ath (Item			reet, Ba	altimore,	Mary]	land 21	201	
	U		At Date filed (March Date Variation	WINCO / ICD	-i- C'								

State Registrar

OCT 0 8 2004

Hospitel or Attending Physician: After death. after death Director:

27. Manner of Death 1 Natural 5 Pending 2 Accident

investigation 6X Could not be determined 4 Thomicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 9-29-04

28c. Injury at Work? 1 ☐ Yes 2 ▼ No Unknown ^M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Unknown 28f. Location (Street and Number or Rural Route Number City or Town, State) 84 Battersea Rd.

Ocean Pines, Md

House 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number OCME

29d. Date signed (Month, Day, Year) September 30, 2004

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Certification:

à

To the Hospitel within 24 hours a To the Funeral D

3 ☐ Suicide

29b. Signati

32. Registrar's Signature

Space

	For State Ragistrar	State o	f Marylan		artment of I tificate of			jiene _{lag. No} ? ∩	n.	31955	
	1. Decedent's Name (First, Middle,	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death	
ian cal	Ted Cochran	2004	4:42 A M								
ner	4a. Facility Name (If not institution,	, give street and nu	mber)		4b. City, Town, o	or Location of Death	1		nty of Death		
	SAINT JOSEPH M				TOWSON				TIMORE		
	, , , , , , , , , , , , , , , , , , , ,	6. Sex 1 2 KM 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day	r, Year)	Cou		
	219-10-8886 Usual Residence of Decedent	TE	79				Feb. 2,	1925	Nor	th Carolin	
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation		· <u>-</u>			10d. Inside City Limits	
ţ	Maryland Harfor	rđ	C	hurchv:	ille					1 □ Yes 2 □ X 9o	
Director	10e. Street and Number			IIGI CIIV.	10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
a D	2908 Rolling (Green Dri	ve		210	028			USA		
Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or No-	14. A	lace - Ameri		
F	1 ☐ Never Married 2 🔀 Marri		2 No	i	Yes 2 No		7 110011, 5101,	Spec		610.	
db	3 Widowed 4 Divorced	Year or D							Wh	ite	
ete	15. Decedent (Specify only highes			(Give	lent's Usual Occu kind of work done	during most of wor	king	16b. Kind of	Business/In	ndustry	
m	Elementary/Secondary (0-12)	College (1-4or 5+)	_	OO NOT use retire	,		D7 =	3		
Completed	12 17. Father's Name (First, Middle, I	Last)		Sares	S Consult		ne (First, Middle,	Real E Maiden Sum		l	
Be	Andrew Mack Co					Annie	Carolin		_		
2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)										
				1		Green Dr					
1.19	Helen Cochran 20a. Method of Disposition	7 WILE	20b. F	lace of Dispo	sition (Name of		Date	20c. Locatio			
	1 🔀 Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp		State		natory or other pla		0 0 04	m-1 =2			
	21. Signature of Funeral Service L		i be.	22	Name and Addre	Grdns. 1			I, I'd	ryrand	
	McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009										
	23a. Part1. Enter the di lease r	complications that	caused the deat						Mary	Approximate	
	shock, or heart failure. List of Immediate Cause (Final				52.5					Interval Between Onset and Death	
	disease or condition resulting in death) a. CARDIO-RESPIRATORY ARREST Due to (or as a consequence of):										
	CODOMADY ADTEDY DICEACE										
ē	if any, leading to inmediate . Due to (or as a consequence of):										
Examin	Cause (Disease or injury that initiated events										
Exa	resulting in death) Last		JLAR HEA (or as a consec								
cal		d. STATI	JS POST	BILATE	ERAL_TOTA	AL KNUE E	RPLACEME	AT.	-		
Med	IF FEMALE:									Kim re-	
an/	23b. Was decedent pregnant in the past 12 months?	1 Live	s, outcome of pregnancy _ive birth 2 ☐ Fetal death 3☐Ectopic pregnancy					1 .	Date of deliv Month	delivery Day Year	
sicl	1 Yes 2 No	4□Pregi 9□Unkn	nant at time of o lown	leath 5□] Other (specify) _				,		
Physician/M	Part II. Other significant condition	Me contributing to (leath but not see	ulting in the u	adortvina causa a	won in Part I	23e Did to	bacco use co	ontribute to t	the cause of death?	
b	DIABETES	ans continuenting to c	leath put not les	aliting in the di	idenying cause gi	veninranti.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Frobably 4 Unknown			
ted							127				
g	HYPERTENSION						24a. Was a autop perfor	sy	b. Were auto prior to co death?	opsy findings available empletion of cause of	
1	RENAL INSUFFIC	IENCY						2 No	1 Yes	2 No	
Completed		-			0:	hor	th (Check only or				
Ве Соп	25. Was case referred to medical examiner?		Inpatient 2		1 3 DOA		ome 5 Resid			fy)	
To Be	25. Was case referred to medical examiner? 1 Yes 2 No		ad Indiana	28b. Time of	28c. Inju	280. Describe fi	ow injury occ	28d. Describe how injury occurred			
To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Magner of D ath 1 Natural 5 Pendin	28a. Date (Mor	of Injury oth, Day Year)	Injury	14 15	7 7 2 7 7 10	28f. Location (Street and Number or Rural Route Number,				
To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of D ath 1 Natural 5 Pendin 2 Accident	28a. Date (Mor	nth, Day Year)]Yes 2□No	28f Location /S	treet and Nu	mbor or Pur	al Pouto Number	
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Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Magner of D ath 1 X Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide	g 28a. Date (Mor gation not be ined 28e. Place	nth, Day Year) e of Injury - At h ling, etc. (Speci	ome, farm, str (y)	eet, factory, office		City or Tow	n, State)			
Certification: To Be	25. Was case referred to medical examiner? 1	gation not be inned 28e. Placined 28e. Placined 29e. Placined 28e. Placi	e of Injury - At h ling, etc. (Speci e best of my kno pasis of examina	ome, farm, str fy) owledge, death	eet, factory, office	ime, date and place	City or Tow	n, State)	manner as s	stated.	
To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of D ath 1 Notaural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ 29a. Certifier 1 Certifyin	gation not be ined 28e. Place build 28e. Place build 28e. Place build 28e. Place and mar	e of Injury - At hing, etc. (Speci	ome, farm, str fy) owledge, death ation and/or in	eet, factory, office n occurred at the t vestigation, in my	ime, date and place	City or Tow , and due to the c rred at the time, c	n, State)	manner as s e, and due t	stated. o the cause(s)	
edical Certification; To Be	25. Was case referred to medical examiner? 1	gation not be ined 28e. Place build 28e. Place build 28e. Place build 28e. Place and mar	e of Injury - At h ling, etc. (Speci e best of my kno pasis of examina	ome, farm, str fy) owledge, death	n occurred at the trestigation, in my 29c. Licen	ime, date and place opinion, death occu ise number	City or Tow , and due to the c rred at the time, c	cause(s) and date and place	manner as s e, and due t ned (Month,	stated. o the cause(s)	
edical Certification; To Be	25. Was case referred to medical examiner? 1	gation not be ined 28e. Placing Physician: To the Examinar: On the band mar	e of Injury - At h ling, etc. (Speci.	ome, farm, str fy) owledge, death ation and/or in	n occurred at the trestigation, in my 29c. Licen	ime, date and place opinion, death occu	City or Tow , and due to the c rred at the time, c	ause(s) and date and plac	manner as s e, and due t ned (Month,	stated. o the cause(s)	
edical Certification; To Be	25. Was case referred to medical examiner? 1	gation not be ined 28e. Placified 28e. Placified 28e. Placified and mar and mar who completed cau	e of Injury - At h ling, etc. (Special e best of my known sasis of examinatine stated.	ome, farm, str y) owledge, death attion and/or in m 23a) (Type,	n occurred at the tyestigation, in my 29c. Licen Print)	ime, date and place opinion, death occurse number 31826	City or Tow , and due to the c rred at the time, c	cause(s) and late and place	manner as s e, and due t ned (Month,	stated. o the cause(s)	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For Stata Registrar	State of Mai	-	epartment of the Certificate of		Mental Hy	4 THE LAND OF THE	
		Decedent's Name (First, Middle, La	ist)				2. Date of De		3. Time of Death
Physici /Medic		Floyd Jose			Septem	ber 28 1	LOOH 12:35P M		
Examir		4a. Facility Name (If not institution, given		or Location of Deat		4c. County			
		Mercy Medical		ltimore					
Funeral Director		438-20-0708	Sex. 7. Age	78 Yrs	Months Days	Hours Min.	8. Date of Bi (Month, D Jan. 30	J, Year)	9. Birthplace (State or Foreign Country) Louisiana
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Mar Mar	ctor	Louisiana			New	0rleans			1√ Yes 2 No
or 28	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of V	
death with the Maryland ms 23a or 28e-f show Finust be rediffed at		1438 Spa:				70117			ted States
5 2 3	by Funerai	11. Marital Status 1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 → No		Specify Yes or No to Rican, etc.)	5 Specify	e - American Indian, k, White, etc. Black
72 hc	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occup	pation during most of wo	rkina	16b. Kind of Bu	siness/Industry
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all opportunit of Health and Mental Hyglene. Myortent: If them 27 is marked other then "naturel; or myortent; of the marked other then "naturel; or myortent of the marked other then "naturel; or myortent."	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+))	ive kind of work done e. DO NOT use retire Truck	_{d)} Driver	,	Gov	vernment
nd nd	BeC	17. Father's Name (First, Middle, Last				18. Mother's Nai		, Maiden Sumam	θ)
yla yla went Ment Ment Ment Ment Ment Ment Ment M	10	Andrew						a Adams	
Mar Mar Mar Mand Hand Tism treum		19a. Informant's Name/Relationship		19b. N	ailing Address (Street				
1 and 1 and		Flora Lawson 20a. Method of Disposition	- Daughter	20b. Place of D	5605 Rolli sposition (Name of	1	Capitol		S, MD 20743 City or Town, State
Fages ment of tent: If If If If If If If If If If If If If		1 Durial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Speci	(y)	Lincoln	rematory or other pla Memorial	Cem. 10/	5/2004		land, MD
Ball permit Depart Import eny in		21. Signature of Funeral Service Lice	Tayres	TIL	22. Name and Addres	nning Rd	. N.E.	Funeral Wash., I	
Physician /Medical Examiner	<u></u>	23a. Part1 Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a	consequence of)	lung ca	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate base. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
Box sath cert attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc; 5 □ Other <i>(specify)</i> _	1		23d. Date Mon	e of delivery hth Day Year
rds, P quires that on signed t	by	Part II. Other significant conditions	contributing to death but	ren in Part I.		tobacco use contri Yes 2□No	ibute to the cause of death?		
Division of Vital Records, P.O. To the Hospitel or Attending Physicien: The law requires that the de within 24 hours after death. To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deliached	Completed						24a. Was auto perfo	psy promed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 \sum No
Vita icien sertifii	Be	25. Was case referred to medical examiner?	Hospital:		0		ath (Check only o		
ion of nding Physith. : After this of funeral directions of the state	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day)		y Wor	4 Lituising i		Residence 6 Other (Specify) Coribe how injury occurred	
Division or the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, (Specify)	street, factory, office		28f. Location (. City or To	Street and Numbe wn, State)	or or Rural Route Number,
e Hospii 24 hour e Funer	Medicai (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of eand manner state	xamination and/o	eath occurred at the tir r investigation, in my o	me, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
		> Dulling	^		DN	0854		9/28	12004
3			eberg 30	I ST		lace (Baltin	ore mal	21202
Sta Registr		31. Date filed (Month, Day, Year) OCT 0 8 2004	32 Registrar	s Signature	oaks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 1 2004 4:30 AM M Ethel Mae Davis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth May 2, 1910 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 🛱 F 94 219-12-1851 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21701 237 Wyngate Drive Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2X No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mollie Sulcer David P. Flook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mollie A. May, daughter 237 Wyngate Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Reformed Cemetery Oct. 4, 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Middletown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licenses M00255 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): wisser Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification; 5 Pending investigation 1 Yes 2 No

The law requires that the daath certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, the attending physician certificate Physician: this death.

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Examiner

Funeral

Director

27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, it a Medical Examinar mast be notilized at

with the Maryland

permit. Pages 1 and 2 should be flied within 72 hours after death with Department of Health and Mental Hygiane. Important: if item 27 is marked other than "--- any injury or other traumes".

Physician

Examiner

/Medical

ģ ed by the a signed t cate has been sig , page 2 should b funeral director, or Attending hours after deati unerat Director: filled in by 24 hours a e Funerat I Hospital within 2 the

27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 | Homicide

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D16675

MO 21716

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October 1, 2004

cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl PLGMER

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Medical

State Registrar

MN

State Registrar

31. Date filed (Month, Day, Year) OCT 0 8 2004

ANA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Docks

10:10 AM

Please 7	Type or	Print	in	Black Ir	ndelibl	e Ink.	Ensure	All	Copies	Are L	egible.
							4.4				

			State of Maryland / Department of Health a 1 - Stete Registrar Certificate of Death		tal Hygier	2001.	31859
			Decedent's Name (First, Middle, Last)		ate of Death	Day Year	3. Time of Death
	Physici /Medio		Alan Leon DeBoard			5, 2004	10:10 A ^M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death		c. County of Death	
			Harford Memorial Hospital Havre de G			Harfor	
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Und	Min. (A	ate of Birth Wonth, Day, Yea	9. Birth	
	Director		215-56-2778 52 Yrs.	Ju	ıly 26,	1952 Mar	yland
	and *		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl f sho	5	Maryland Harford Joppa				1 ☐ Yes 2 📉 No
	158 288	rec	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Cou	ntry?
	3a or	ā	1004 Trimble Road 21085			USA	
	death ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control Original Control Original Cont	igin? (Specify Y	Yes or No-	14. Race - Ameri	
9	after or ite		1 Never Married 2X Married 11X Yes 2 No		i, etc.)	Black, White,	etc.
8	72 hours after death with the Maryland natural', or items 23a or 28a-f show deal Examinar must be notified at	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			Specify:	√hite
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	st of working	16b.	Kind of Business/In	dustry
2	within and the second s	d L	Elementary/Secondary (0-12) College (1-4or 5+)				
5	e filed v of Hygie other t		12 Carpenter 17. Father's Name (First, Middle, Last) 18. Mothe	er's Name /Firs	st, Middle, Maid	onstruct:	Lon
anc	ould be fi Mental H arked ot atic ever	Be			auranda		
ž	2 should be and Mental is marked is raumatic ev	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number				
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		To peak to see the				
	is 1 and 2 of Health item 27 I		Donna F. DeBoard / Wife 1004 Trimble Boad 20a. Method of Disposition (Name of	Joppa Date	Maryl	Location - City or To	own, State
٥	ages nt of Hit		1 Surial 2 Cremation 3 MRemoval from State cemetery, crematory or other place)	10 11 0	0356		
Baltimore,	it. Partmer rtmant rtant njury	1	4 □ Donation 5 □ Other (Specify) Owen Family Cemetery □ . 21. Signature of Funeral Service Licensee 22, Name and Address of Facility			th of Wil	.son, VA
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		McComas Funera				000
		1. 12	1317 CONCIDENT	Y ROSO,	Abingo piratory arrest.	[on, MD 2]	()()9 Approximate
ı			23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
П	Physician /Medical		disease or condition a.	novomm	re		
П	Examiner		Due to (or 's a con a uence of):	11.000			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(0.01_	-		
	uted I Insit	min	Cause [Disease or injury				
	akecu n and	Examin	that initiated events c. resulting in death) Last Due to (or as a consequent of):				
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cail	d				
.89	ificat g phy as the	edicai),
Вох	leath certific: attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant			23d. Date of delive	ery .
ă	death e atte d for	icia	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 ☐ Unknown				
	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 2	23e. Did tobacco use contribute to the cause		
rds	v require been sig should b				1 🗆 Yes	2□No 3□Prot	ably 4 dilukhown
000	law requires as been sign 2 should be	Completed		2	4a. Was an	24b. Were auto	psy findings available mpletion of cause of
æ	o = 0	E			autopsy performed? ☐ Yes 2 11 →	_ death?	2 No
Division of Vital Records,	ilcian: Th certificate rector, pag	0	25. Was case referred to medical 26. Place	of Death (Che			
\equiv	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nu	ursing Home 5	5 Residence	6 □Other (Specif	y)
0	ig Ph ter th neral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d. D	Describe how inj	ury occurred	
Ö	Attending r death. ector: Atterby the fune	atlo	2 Accident investigation M 1 Yes 2 1	No			
<u>Vis</u>	er de recto	iii	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street a	and Number or Rura te)	l Route Number,
ō	tal or	Certification:					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical	29a. Certifier (Check only (Ch	nd place, and du ith occurred at t	ue to the cause(s) and manner as sind place, and due to	ated. the cause(s)
	To the H within 24 To the F complete	ledi	one) and manner stated.		2015		D V
	To To con	Σ	29b. Signature and title of certifier 29c. License number	215	290. 0	ale signed (Month,	vay, rear)
				~ 1)		1 2 1 2 1 6 4	
	211		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nian Ow	e. Ida	redo ino.	mo 21028
	3+1		29a. Certifier (Check only one) 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and concept and manner stated. 29b. Signature and title of certifier 29c. License number 29c. License number 29c. All of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature			`	
	Sta Registr	te	31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature & Sports				
	negisti	aı	/ / / / / / / / / / / / / / / / / / / /				

Ivan R. Elmore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06266 1- For Unpend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. MAN 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** September 29, 2004 0114 A Ivan R. Elmore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Fort Washington Hospital Center Fort Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1₹M 2□ F Yrs 46 1958 577-86-7826 Wash., Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1X Yes 2 □ No Director Maryland Prince George's Clinton the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8203 Bathgate Ct. 20735 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, Whiterete an ∏XYes 2 ∏ No fYes. Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2)X No Specify: Specify: American 2 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than any injury or other traumatic event, Item Elementary/Secondary (0-12) College (1-4or 5+) 12th Government Hospital Escort 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivan Randolph Elmore, Sr. Dorothy Thompkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura D. Elmore - Sister 8203 Bathgate Ct., Clinton, MD 20735 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 10/6/2004 Suitland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fufferal Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive atherosclerotic cardiovascular disease Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of): ng physician and as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 1 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

100 yes 2 □ No 24a. Was an certificate has autopsy performed 1 Yes 2 □ No Hospital or Attending Physician: 4 hours after death. Funeral Director; After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 ☐ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MENOREME 31. Date filed (Month, Day, Year)

cai

32. Registrar's Signature

30. Name and address of person who completed cau per death (Item 23a) (Type, Print)

and manner stated.

ans

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 29, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9.55 M) të phanic 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVICLO n/a Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. Apr 15, 1914 Johns Hankens Care Center 0/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2 F Maryland 216-24-4237 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Michigal Experience must be notified at 1 Yes 2 No Director Md. n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2816 Hudson Street 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mental page. Elementary/Secondary (0-12) College (1-4or 5+) Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK Caroline May ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Delbert Avenue Baltimore, Md 21222 Zebron Stephanie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cem. Oct 4,04 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses KuloT 1201 Dundalk Avenue Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): Se olny S resulting in death) /Medical Examiner Ganbrene ~122/C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I Hecords, P.O. Box 68760, <. The law requires that the death certificate be executed burial-transit ic bet Due to (or as a consequence of): the attending physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Day 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Pes 2 🗆 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2 No 1 🗆 Yes Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 033316

State Registrar

Michelet

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Holan Bayuni Cite Beldinge Morning

who completed cause of death (Item 23a) (Type, Print),

32. Registrar's Signature

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Bollanten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 00:23AM Richard N. Foltz, Jr. TOBERZ 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 179Nes 4e 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 157M 2□F Director 216-07-2906 86 1918 Maryland 10, Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show rai', or iteme 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5627 Huntsmore Road 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 1943 white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'netural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard N. Foltz, Sr. Elizabeth A. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Foltz - wife 5627 Huntsmore Road, Halethorpe, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 10/05/04 1 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Elkridge, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. tukman 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Vasevlar Physician Coronary lisese Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to or as a consequence of: Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? No. 1 ☐ Yes 20 No 1 Tyes Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 0 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Division Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours after To the Funeral Dire ö filled the Hospitel 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 2, 2004 Ub055 849

State Registra

DHMH 17 Rev 1/2001

22. Registrar's Signature

STAGNES HOSPITAL GOOS CATON

30. Name and address of person who completed oxuse of death (Item 23a) (Type, Print)

BERGESON

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L		-	giene Reg. No. () () L	31863
	Physic		1. Decedent's Name (First, Middle, La Edward Fran	st) iklin Fry				2. Date of De Month Octob	Day Year	3. Time of Death 4 8:36 P M
	/Medi Examir		4a. Facility Name (If not institution, given		ospital	4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. S 577–14–9561	ex 7. Age	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 15	th 9. Bir ay, 1917 M	rick thplace (State or Foreign ountry) aryland
	72 hours after death with the Maryland natural', or Items 23e or 28a-f show Iteal Examiner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Frede 10e. Street and Number	erick	10c. City, Town or Lo	Adams tow	n		10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√ No
	ath with	Funeral Director	5781 Moreland Dri			2	1710		U	.S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show may injury or other traumatic event, the Medical Examinat must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	⊳1941 td	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		
21215-0036	I within 72 ho iene. r than "natur ihs Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	(Give	dent's Usual Occupa kind of work done d DO NDT use retired, lder	ition luring most of work)	ing	Residentia	ŕ
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Scott L. Fry				Nellie	Stunk!		
	and 2 sho salth and n 27 Is my ier trauma		19a. Informant's Name/Relationship (Gertrude Brown Fi				d Drive,	Adams to	er, City or Town, State, 2 DWn, Maryla	
altimore,	it. Pages 1 rtment of He rtant: If iten njury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Onation 5 ☐ Other (Specification of Europe Specification of Eur	1)		natory or other place Cemetery	October	11, 20	20c. Location - City or 4 Point of	Rocks, MD
Ba	permit. Departr Importa eny inje		21. Signature of Funeral Service Licer	Dante-	(MOOQ21	Z. Name and Addres Keeney and 106 East	d Basford			MD 21701
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Septi	6.		g, such as cardiac o	or respiratory ai	rrest,	Approximate Interval Batween Onset and Death
		xaminer	Sequentially list conditions, if any, leading to immediate East and the Cause (Disease or injury that initiated events resulting in death) Last	С.	a consequence of):					
8760,	ate be e hysiciar the buris	dical E	· ·	d						
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ►No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions of	-	-		n in Part I.	23e. Did to	obacco use contribute to	the cause of death?
l Reco	The ste h	Completed	19 tenuscher ct	Luncor				24a. Was autop perfo 1 Yes		topsy findings available completion of cause of
on of Vital Records,	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Anpatiel 28a. Date of Injur (Month, Day		f 28c. Injury Work	4 Nursing Ho	n <i>(Check only o</i> me 5 ☐ Resid		sify)
Division	al or Atten s after deat I Director: d in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, str . (Specily)			28f. Location (S City or Tow	Street and Number or Ru vn, State)	ral Route Number,
	he Hospiti n 24 hours he Funera pletely fille	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination and/or in-	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the ded at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To ti withi To ti	M	29b. Signature and title of certifier	2.00	im Den	29c. License	number 14851		29d. Date signed (Month	n. Day, Year)
	24		30. Name and address of person who Janet Ciarkowsl	ki, M.D., 9	9093 Ridge		d, Suite	104, Fr	rederick, M	21701
	Sta Registr		31. Date filod (Month, Day, Year) OCT 0 8 2004	32. Registra	r's Signature	books				

			1 - State Registrar	State of Maryl	land / Depa		Health and	Mental Hyg	_	J. 31864
	Physici		Decedent's Name (First, Middle, Last) SANDRA)		F	RICK	2. Date of Dea Month October	th Day	3. Time of Death Year 004 5.54 A M
	/Medi Examir		4a. Facility Name (If not institution, give THE JOHNS HOPKIN		42	4b. City, Town, o	or Location of Deat		4c. County o	of Death
	Funeral Director		220 10 1101	7. Age (In	yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days			1943	Birthplace (State or Foreign Country) Maryland
	Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimol		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	with the 3e or 28e	i Direc	10e. Street and Number 5724 Utrecht Road			10f. Zip Code 21206		1	log. Citizen of W	hat Country?
036	be filed within 72 hours after death with the Maryland hat Hygiene. do other then "neturel", or Items 23e or 28e-1 show event, itte Medical Examplest must be incitined at	by Funeral Director		12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American Indian, K, White, etc. White
215-0	ithin 72 ho ie. ien "netur Wedicul	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Bus	siness/Industry
Maryland 21215-0036	be filed ntal Hygi od other event, I	Be	12 17. Father's Name (First, Middle, Last)	n/a	Hom	emaker		me (First, Middle, I)
laryla	s 1 and 2 should be f Health and Mental item 27 Is marked o other treumetic eve	P.	Joseph Anthony 19a. Informant's Name/Relationship (Ty,					ural Route Number		
ore, N	Pages 1 and 2 nent of Health int: If item 27 I		Ronald S. Frick-husband 20a. Method of Disposition 1 & Burial 2 Cremation 3 CR	lemoval from State	b. Place of Dispo cemetery, cres	sition (Name of matory or other pla		Date		City or Town, State
Baltimore,	permit. Pages of Department of Himportent: If ite any injury or of once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			2. Name and Addre	-			e, MD . Funeral Home
760,	Wedical Examiner ie pariginal and provided in principle	cai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flaring, larung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	nfarction sequence of): induced magnisms of)	0			W	Approximate Interval Batween Onset and Death Eighteen hours
.O. Box 68	The law requires that the death certificate be e. tte has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy	<i>'</i>		23d. Date Mont	of delivery h Day Year
rds, P	w requires that been signed E should be deta	by	Part II. Other significant conditions con presumed multiple	tributing to death but not	_	nderlying cause giv	ren in Part I.	23e. Did tob		oute to the cause of death?
Il Records,		Completed	pulmonary savcoi	, 1				24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings available or to completion of cause of ath?] Yes 2 🔀 No
on of Vital	Attending Physiclen: The death. ector: Atter this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 1 ☒ Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 🔀 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	ath (Check only one lome 5 Reside 28d. Describe ho	nce 6 Other	
Division	ol or Attendiates after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.		eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tire restigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier Angeline Cher	y, MEDICAL	L DOGTO	29c. Licens RES -	e number		od. Date signed (Month, Day, Year) 6,2004
			30. Name and address of person who co Angeline Chong, The	mpleted cause of death (Johns Hopkins	Hospital,	Print) 600 North	Wolfestre	et, Baltimi	ore, Mary	land 21287
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 0 8 2004	32. Registrar's Si	gnature	ads				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Juan Gresia September 23, 2004 9:55A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8009 Mandan Road #T-3 Greenbelt Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 18, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral X**□M 2□F 562-54-4144 69 Director Argentina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland | Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8009 Mandan Road #T-3 "natural", or Items 23a 20770 Argentina 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1⊠Yes 2□No Specify: Argentinian Baltimore, Maryland 21215-0036 2 Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Banquet Waiter Private permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Juan Nicolas Gresia Pilar Gil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl L. Gresia (Wife) 8009 Mandan Road #T-3, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ⁴ 4 □ Donation 5 Other (Specify) Chesapeake Crematory 9/25/2004 Beltsville, MD A Pineral Se vice Licenses 21. Signature 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 wins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pease or condition resulting in death) IV norsmall cell Lung Cancer Physician 12months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -transit The law requires that the death certificate be executed and Due to (or as a consequence of): as the burial the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary DIDSHULLICE 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 282 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 ⊠Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral D Medical +C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KISWALOR D 50686 9/24/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurdeep Chhabra, M.D. 7247 Hanover Parkway, Suite A, Greenbelt MD 20770 32. Regist ar's Signature OCT 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3 Time of Death Year **Physician** 10/06/2004 7:40 PM Ruth Leona Glacken /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8480 Garden Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/08/1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🛣 F 92 Director 218-10-9168 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 la marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Exam har must be notified at 1 ☐ Yes 2 No Director Pasadena MD Anne Arundel 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code 8480 Garden Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. I a marked other than "natural, or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Dry Goods Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William N. Reeside Florence Watts 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Ia m any injury or other traum 8480 Garden Road, Pasadena, MD 21122 Bessie Wise/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Friends Creek Cem 10/11/04 Emmitsburg, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1ac 1 Ar /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Quallo (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 eq Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3) Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 🗌 Yes 5X Residence 6 □Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Datth 28b. Time of 28d escree how injury occurred e Hospital or Attanding Pl 24 hours after death. e Funeral Diractor: After t Certification: Injury 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature an title of certifier 29c. License number 29d. Date signed YMonth, Dav. Year 30. Name and add mpleted cause of death (Item 23a) (Type, Print) h 000 31. Date filed (Wonth, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1025 PM John Edward OH Grimes Cto ber 2004 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** HUNGE DE GACE

If Under 1 Year If Under 24 Hrs.

Months Days Houre toro itizens Hom. Vursing 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 2, 192 Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Yrs. 235-34-2464 84 Director 1920 West Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show The Medical Exercitive must be notified at 1 ☐ Yes 2 No Maryland Harford Bel Air Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 301 N. Fountain Green Rd. 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 210 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 12 Farmer permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic event, odge. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Virgil Grimes Edna Stoneberger Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark M. Carroll - Guardian 145 Hickory Avenue, Bel Air, Maryland 21014 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bel Air Mem. Gardens 1 Burial 2 □ Cremation 3 □ Removal from State 10/7/2004 Bel Air, Maryland *4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mock T. Pays.

1317 Cokesbury Rd., Abingdon, Maryland 21009

Approximate interval Between the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the corporation of the corpora McComas Funeral Home 23a. Part1. Enter the disease, promplications tha shock, or heart failure. List only one cause or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alnutalin **Physician** 6 WKS /Medical (or as a consequence of): whs **Examiner** Intelration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the ۾ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Old 1 Yes 2 No 3 Probably 4 ☐Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral Completely filled i 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) To MD 32600 10/5/04 whan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Metham In 1106 Revolution It Tarre DE Brane 32. Registrar's Signature 8 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 21000 Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 532 PM GALES PATRICIA 05 2004 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON SOUTHERN NARYLAND HOSPITAL CENTER PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Virginia V. Virginia **Funeral** Days Hours 1 □ M 2√□ F April 21,1939 W. 233-64-7164 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with fine Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Mentical Experiment 200. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince George's Clinton Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9318 Linhurst Drive 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: African American 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mammie Green George Washington ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9318 Linhurst Dr. Clinton, Maryland 20735 Edward L. Gales, Jr (Husband) 20a. Method of Disposition
XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . 2004 Oct. Cheltenham, Maryland Maryland Veterans Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Lee Funeral Home, Inc. 22. Name and Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD20735 mx01Z84 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL **Physician** /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? v 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 27. Manner of Death 1 XNatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 - Homicide 24 hours a 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signatur nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/05/04 D0061415 ress of person who completed cause of death (Item 23a) (Type, Print) M.D. Southern Maryland Hospital 7503 Surratts Road Elinter Md. GAMBHIR, MANISH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 8 2004 Registrar

		1 - For State	State of Maryland /	Depa	artment of H	lealth and	•		gible.	
		- negistrar		Cei	tificate of	Death		Reg. No.	1114	3 869
Physici	an	Decedent's Name (First, Middle, Las	()				2. Date of De Month	ath Day	Year	3. Time of Death
/Medi		Frances C.	Hayden					, 2004		5:03 A M
Examir	ner	4a. Fecility Name (If not institution, give	,		4b. City, Town, o	r Location of Dea	th	4c. Cou	nty of Death	1
٠		Renaissance Garde			Silver	-		Pri	nce Ge	
Funeral Director		5. Social Security Number 6. Se 209–16–2039	x □M 2XIF 7. Age (In yrs. last I	Yrs.	Months Days	If Under 24 Hrs Hours Min		th ly, <i>Year)</i> 1916	9. Birth Cou Penn	nplace (State or Foreign intry) sylvania
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
e-f sh	ctor	Md. Prince G	eorges	Silv	er Spring	5				Y Yes 2 No
with the a or 28 be no	Director	10e. Street and Number 3142 Gracefield	Pond		10f. Zip Code	20.4		10g. Citizen		untry?
eath	erai		12. Was Decedent Ever in U.S.	12.1	209		N		USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, to Modical Examinar months to notificat	by Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Vas Decedent of H Yes, specify Cuba □ Yes 2☐kNo		to Rican, etc.)	i	Race - Amer Black, White cify: U.b. 1	, etc.
21215-0036 od within 72 hours aff gjene. er than "natural", or the Medical Extent		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						WIII	
15-	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	(Give	ent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of	Business/la	ndustry
withigh 72.	E G	Elementary/Secondary (0-12)	9- (CANAL us pretire			Amond	D.	1 0
Hygir Hygir		17. Father's Name (First, Middle, Last)	7 0	ommu)	nication		ne <i>(First, Middle</i> ,			ed Cross
Maryland of 2 should be file lith and Mental Hy 27 is marked oth traumatic event	To Be	Francis Coleman					oeth Nas		airie)	
Mar nd 2 sho lith and 27 is m		19a Informant's Name/Relationship (T) James Michael Gabr			g Address <i>(Street)</i> Westfiel					p Code)
Te,		20a. Method of Disposition	20b. Place		sition (Name of patory or other place		Date	20c. Locatio		own, State
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If itam any injury or othe		1 Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)			cemetery Cemetery	, 000,	- 1			
altil		21. Signatur Fureral Service Lons		22	Name and Addres	s of Facility	Scale Control	waver.	Ly, Ne	w York
Depariment impo		Huge At X		D ₆	Vol Fune	ral Home	NT.7 T.	Joahine	. +	D.C. 20007
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death. Do	not ente	or the mode of dyin	g, such as cardia	c or respiratory ar	rest,	ton,	Approximate
Physician		Immediate Cause (Final	1 1 1		0.0	0	:И.			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence		can	iver w	yn			2 weeks
Examiner				3 Oi).	unkne	Hun	Dhino	su.		
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			-			
3760,ate be executed at the burial-transit	Examiner	Cause (Disease or injury that initiated events								
O, exect an an rial-tr	Exc	resulting in death) Last	Due to (or as a consequence	of):						
1/60, tte be exe tysician a	cal		d							
68 tifica ng ph as th										
h cer endir	N/V	200. Was decedent program	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal deat	h 2	Catania			23d. [ate of delive	ery
P.O. BOX hat the death cert d by the attendin	icia	in the past 12 months?	4☐Pregnant at time of death		Ectopic pregnancy Other (specify)				Month	Day Year
tr the by th	hys	9 🗆 Unknown	9□ Unknown							
Atlanding Physicien: The law requires that the death certificate be executed to death. Atlanding Physicien: The law requires that the death certificate be executed about. Atler this certificate has been signed by the atlending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Med	Part II. Other significant conditions con	ntributing to death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did to	bacco use co	ntribute to tl	he cause of death?
w require been sij							1 🗆 Y	es 2∑No	3 🗆 Prob	oably 4 Dunknown
aw re	Completed						24a. Was	an 24b	. Were auto	psy findings available mpletion of cause of
The Ite has age	E						autop perfor	med?	death?	
ien:	a	25. Was case referred to medical				26. Place of Dea	1 □XYes ath Check only or		1 🗆 Yes	2 140
ysici is ce direc	OB	examiner? 1 ☐ Yes 2 🛣 No	fospital: 1 Inpatient 2 ER/O	utpatient	3□ DOA Othe		ome 5 Resid		ther (Specif	v)
9 Ph 9 Ph Per th	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury Work	at	28d. Describe h			,,
ath.	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Day 10al)	irijury		r ′es 2 □ No				
DIVISION OT VITAI HECONGS, or Attanding Physicien: The law requires that death. Director: After this certificate has been signe in by the funeral director, page 2 should be come.	E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, lactory, office	2000 0	28f. Location (S City or Tow	treet and Nun	nber or Rura	I Route Number,
s afte	Certification:		Danielligi Otol (Opooliy)				Oily or Yow	ii, Sialej		
UIVISION OT VITAI HER INC. To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	e, death nd/or inve	occurred at the timestigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time, o	ause(s) and r late and place	nanner as si , and due to	tated. the cause(s)
of the office of	₩.	29b. Signature and title of certifier			29c. License	number	2	29d. Date sign	ed (Month.	Day, Year)
- S - 0		Lange and Pi	thumang,	MD	D50	1524		-		1,2004
				(Type D	1				,	12004
13		LOVEEN J PUTHU	MANA, 3110 GI	RACI	EFIELD	ROAD ,	SILVER.	SPRIN	G,MC	20904
Sta Registr		31. Date filed (Month, Day, Year) OCT 0 8 20	32. Registrar's Signature	6	Some					,

			1 - For State Registrar	State of M	arylar	•	artmen			and M		giene Reg. No.	200		^	O ** A
	Physici	an	Decedent's Name (First, Middle, Last	ette Louis	o Ho	1+					2. Date of Dea Month Octobe	ath Day	folia of	ear 1	3. Time of	
)	/Medio Examir	_	4a. Fecility Name (If not institution, give			10		Town, or kton	Location o	ol Death	OCLOBE	4c.	County of Cecil		2116	P
	Funeral Director		5. Social Security Number 6. S 219-60-9878 1 Usual Residence of Decedent	□M 2KTE	ge (In yrs. 7	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Day SEPT 20	y, Year)		Countr	oce (State o y) /land	or Foreign
	the Maryland 28a-f show	Director	10a. State 10b. County Maryland Cecil 10e. Street and Number			ty. Town or Lo 1kton		Code				10- 00	(100		d. Inside C	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28a-f show aumatic event, the Mydical Exactivat must be notified at	by Funeral	235 Oldfield Poi 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	,	1	Was Dece	1921 lent of Hi ofy Cuba	ispanic Oriç n, Mexican Specify:	gin? (Spe i, Puerto I	ocity Yes or No- Rican, etc.)	Ur	aited 4. Race - / Black, V Specify:	Sta	tes n Indian, tc.	
Maryland 21215-0036	within 72 ho iene. r then "natur ibe Medice.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or	5+)	life. I	dent's Usua kind of woi DO NOT us nemak	rk doné d se retired	durina most	t of workii	ng	_	nd of Busin			
yland 2	Mental Hygi Mental Hygi arked othar atic event,	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Coulbou						Ber	tie	(First, Middle, Legate	Maiden	Sumame)			
, Mar	and 2 sho ealth and n 27 ie m		19a. Informant's Name/Relationship (7 Louise Patchell/			1018	Unio	n Ch			/ Elkto					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta importent: If item 27 is marked eny injury or other traumatic es <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Specify	y)	Gi	Ptace of Dispo Pemetery, com IPIN Mo Morial	anor Park	ther place	2	otob 004	er 5,	Elk	ton,			
Ba	Departition Departition important		21. Signature of Funeral Service Licen	Luk		1(D3 W.	Sto	<u>ckton</u>	Str	rals, F eet, El	kton	, Mar			
8760, ×	Cate be executed hysician and physician and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACJ Due to (or as	a consection a consection	GREquence of):	32A	tL	HEY	mor	NHAG				Approximatinterval Bet Onset and I	ween Death
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 15 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fete	eldeath 3	Ectopic pro					2	3d. Date of Month			Y ear
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions o	ontributing to death b	out not res	sulting in the ur	nderlying ca	ause give	en in Part I.				se contribut			
ai Reco	ysician: The law r is certificate has be director, page 2 sh	Completed									24e. Was a autop perfor 1 \(\subseteq \text{ Yes} \)	sy	24b. Were prior death	to comp	y lindings a ptetion of ca	available ause of
of Vit	Physicial this certifial al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatien			or: 4 □ Nur		(Check only of ne 5 ☐ Resid		Other (5	Specify)		
Division of Vital Records,	Attending I r death. ector: After by the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		jury - At h	28b. Time of Injury ome, larm, str	М		at i? ∕es 2 □ N	40	28d. Describe h	treet and		r Rural F	Route Num	ber,
_	ospitel or 124 hours atte e Funeral Dir letely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examina	owledge, death ation and/or inv	occurred avestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the ded at the time, d	ause(s) a late and	and manne place, and	r as stat due to th	ed. ne cause(s)
	To within To the comp	Me	29b. Signature and title of certifier	- MD				Do				18	signed (M	Conth, Da	ay, Year)	
	8		30. Name and address of person who			п 23а) (Туре,	Print)	20	2 141	-20 0	IN 5500	92	1			
	Sta		31. Date liled (Month, Day, Year)	32. Regist	rar's Signa	ature 4	6	2. 10			nD 2					

DHMH 17 Rev 1/2001

OCTOBER

MADELINE

HARRINGTON,

WALLACE HERON 04-6389 dap

			For State	State of Maryland / Dep	partment of Health and ertificate of Death		000 0:00	0
			Registrar 1. Decedent's Name (First, Middle, Las		eruncale of Dealif	2. Date of Death	g. No. 3. Time of De	ath
	Physicia	an	Wallace H.	Heron, III		Month OCTOBER	Day Year	М
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		3, 2004 3:20p	
	Examin	er	BAYVIEW MEDICAL CI		BALTIMORE CIT		n/a	
	Europal		5. Social Security Number 6. Se	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	9 Date of Birth	9 Birtholana (State or Fr	preign
	Funeral Director		216-66-3384	M 2□F 47 Yrs.	Months Days Hours Min.	Feb. 16,	1957 Maryland	0
			Usual Residence of Decedent					
	rylan	_	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City L	
	Ba-f s	cto	Md. n	/a Ba	altimore			
	or 2	Director	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Country?	
	ath w	ral	112 North Hav		21224	N	USA	
	er de	Funeral	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No	 Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 	to Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	Ir, or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White	
Ö	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jodi Examirar nust be notified at	ted	15. Decedent's Ed	ucation 16a. De	cedent's Usual Occupation	16	6b. Kind of Business/Industry	
215	within 7. ene. than "n	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done during most of wo b. DO NOT use retired)	nking		
21	e filed within al Hygiene. other then vent, the Ma	Completed	12th	Sec	curity Guard		Security	
nd	be filed within 72 hours after death with the Marylan ital Hygliene id othar than Insturel', or Itams 23a or 28a-f show event, the Mcdical Examinational be notified at	Be (17. Father's Name (First, Middle, Last)	a T		me (First, Middle, Ma	· ·	
Maryland 21215-0036		မ	Wallace H. Her				Conrades	
<u>Jar</u>	C/ 100	2	19a. Informant's Name/Relationship (7		illing Address (Street and Number or R		-	
45	an eall m 2		Patricia K. He 20a. Method of Disposition		N. Haven St. B		Md . 21224 Dc. Location - City or Town, State	
آو	igas it of h		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	rematory or other place) v Crematory 10-	11	altimore, Md.	
Baltimore,	it. Pa rtmer rtant njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Stylice Licenters 	A			i Funeral Home,	PA
Ва	permit. Pagas t Department of H Important: If its any injury or otl once.	6 6	And tendor	rolon)	1201 Dundalk Av	enue Bal	timore, Md 2122	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arres	et, Approximate Interval Betwee Onset and Dea	n
1	Pnysician	å id	Immediate Cause (Final disease or condition	HYPERTENSIVE A	MERDILLEROTIC CH	ROIDVAIU		LI I
	/Medical- Examiner		resulting in death)	Due to (or as a consequence of):			ASE	
	LAMITHE		Sequentially list conditions,	b. Due to for as a consequence of				-
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Directo (oi va a consequence of				
_	xacui and	xar	that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
8760,	ficate be exacuted physician and is the burial-transit	dical E		d				
687	ficate p physics the	edic		. 0.				
Вох	The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 C E-1i		23d. Date of delivery	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Yea	r
P.0	that the de led by the a detached	hys	9 🗆 Unknown	9□ Unknown				
	es tha igned be de	by F	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of deat	
ecords,	w requir been si should	ted				1 Ves	2 No 3 Probably 4 Monk	nown
ecc	e law r has be je 2 sh	Completed			· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy	24b. Were autopsy findings ava prior to completion of caus	ilable e of
E E		Con				perform 1 ☐ Yes 2	ed? death? XNo 1 ☐ Yes 2 ☐ No	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	I de la contraction de la cont		ath (Check only one		
of	99 44 1	은	1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 XX €R/Outpat			ce 6 □Other (Specify)	
		ion	27 Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injur	y Wark?	28d. Describe how	injury occurred	
Sic	uttandii death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be			28f Location (Stre	eet and Number or Rural Route Number	
Division	l or Attane after death Diractor:	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	Street, factory, office	City or Town,		*
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencempletely filled in by the fune	edical C		ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.				
	o tha ithin i o tha emple	Med	29b. Signature and title of certifier	and mainer stated.	29c. License number	290	d. Date signed (Month, Day, Year)	
	6 4 € 4		D. Quat	7	OCME		OCTOBER 7, 2004	
	6		30. Name and address of person who	completed cause of death (Item 23a) (Typ	pe, Print)			
	۲				11 Penn Street, Ba	altimore.	Maryland 21201	
•,	Sta	ate	31. Date filed (Month, Day, Year) 8 2					
	Regist	rar	0.0100					

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H <i>rtificate of l</i>			ene g. No. A. A	01070
			Decedent's Name (First, Middle, Las	()				2. Date of Death	, = 9 0 +	3. Time of Death
	Physicia		Charles L	Har	L 11			Month Oct	3rd 200	4.30 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	Je	4c. County of Deal	1
			Riverview Care	Center		Essex If Under Tyear	If Under 24 Hrs.	O. D. J. J. Diale	Balti	MOYE hplace (State or Foreign untry)
	Funeral		5. Social Security Number 6. So	ex 7.Age ZIM 2□F	(In yrs. last birthday,	Months Days	Hours Min.	8. Date of Birth (Month, Day,		
	Director		219-42-/135	7 2	61 Yrs.			02/15/	1943	MD
	ind *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	anyla sho	<u> </u>			,,					1 ☐ Yes 2% No
	Ba-f	ctc	MD Baltim	ore	Raspebo			140	0.00	-1-0
	or 2	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a	ral	4322 Woodlea			2120			USA	
	r deg	Funeral	11. Marital Status	Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	íspanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it		1 Never Married 2 Married	1 ☐ Yes 2 X N If Yes, Give	0	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
Ö	ural',	d by	3√2 Widowed 4 □ Divorced	Year or Dates:					(a) (c) 4 (B	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. the than "netural", or Itams 23a or 28a-f show the transfer must be pudified at int, the Medical Evander must be pudified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup a kind of work done o DO NOT use retired	durina most of worki	ng	16b. Kind of Business	industry
2	han ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5-	-)		"/		Cr. 1 T 1	
2	led v tygie her t		17. Father's Name (First, Middle, Last)	0	ETE	ectronics	18. Mother's Name	(First Middle M	Steel Ind	uscry
unc	be finds the period of others	Be		G						
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiens. If itam 27 is marked other than "netural; or itams 23a or 28a-f show or other traumatic event, the Medical Examinet must be publical at	To	Charles Leroy Har		10h Mail	ing Addross (Street		h Newton	Ω City or Town, State, I	Zin Code)
<u>A</u>	12 st h and 7 is n traun				27.57.9		CONSTRUCTION - CONSTRUCTION	min sensor s	27.226	
	ss 1 and 2 of Health itam 27 i	1 3	Michael Hart () 20a. Method of Disgosition	Son)	20b. Place of Disp	Heathrow		o., MD	20c. Location - City or	Town, State
0	Pages 1 nent of H int: If its ury or ot		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or other plac	(e)			
Ë	Pa mer ury		' 4 ☐ Donation 5 ☐ Other (Specify		Metro Ci			06-2004_	Baltimor	
Baltimore,	permit. Page Department o Important: If any injury or once.	0. 9	21. Signature of Euneral Service Licer				aco Ave I		dale Funer MD 21237	al home
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not er	ter the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bac	+000=	1200	monia			Onset and Death
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	Examiner		Constant Notice and delices	h						
		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	Due to (or as a	t consequence of).					
	cutec nd ransi	Examiner	that initiated events	с						
oʻ	e exe ian a irial-t	Ĕ	resulting in death) Last	Due to (or as a	consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		d						
9	ng pl	Med	IF FEMALE:							
Box	th ce rendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		□Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
	requires that the death certific een signed by the attending F nould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)			To out the	Day . ou.
P.O.	at the	Phy	Part II. Other significant conditions of	antibuting to don't by	it not reculting in the	underhing cause an	roe in Part I	23e Did toh	pacco use contribute to	the cause of death?
	res th	by	MIAL COMMISSION		c(ens		on an anti-	1 □ Ye		robably 4 □Unknown
ord	w requir been si should	Completed	10(1)	16 3	C(2/01					
Ö	> Q to	pje						24a. Was an autops	n 24b. Were at prior to	utopsy findings available completion of cause of
<u>س</u>	The law cate has page 2:	5						perform 1 Yes 2		2 □ No
of Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			0.1	26. Place of Deat	n (Check only one	θ)	
Ž	ys dis	은	1 ☐ Yes 2 ☐ N o	Hospital: 1 ☐ Inpatie			4 Aursing no		nce 6 Other (Spe	city)
п		on:	27. Manner of Death 1 Ø atural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe no	w injury occurred	
Sio	eath.	cati	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □ No	001 L		
Division	or Atl	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, s :. <i>(Specil</i> y)	treet, factory, office		City or Town	reet and Number or R i, State)	urai Houte Number,
	urs a	ပိ	an Cariffic attion in			ab a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a sala a		and due to the sec		and the state of
	To the Hospital or Attending within 24 hours after death. To the Funarel Director; After completely filled in by the fune.	edical	(Check only 2 Medical Example)	ysician: To the best on niner: On the basis of and manner sta	examination and/or i	nvestigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
	omple	Me	29b. Signature and title of certifier)		29c. Licens	se number	29	9d. Date signed (Moni	h, Day, Year)
	- > - 0		_/	~_		Dh	3725		10/4/0	141
	1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)	- 1 - 3		12	altimers
	'n	1	TANIO MAH	MUUD 2	01-109	Back	River	Necle	= Red n	10 21701
	St	ate	31. Date tile Month Say Xay 4	32. Registra	ır's Signature	land,				n, Day, Year) ULI altimure 11 21221
	Regist		UC 1 V O 2004	1	IN P	wills!				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day October Barbara Mae Jackson 2001 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arui GlenBurne 0 HOSPITA nne If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Director 213-34-3246 67 1. 1937 FEB. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow or other treumatic event, the Medical Examiner wast be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 100 Longwood Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Child Care Provider Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Francis Farrell Margaret Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence M. Jackson - husband 100 Longwood Avenue, Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department Importent: If eny injury or once. 10/9/2004 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park Glen Burnie, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOXI 2 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin The law requires that the death certificate be executed use as the burial-tran Division of Vital Records, P.O. Box 68760 physician by Physician/Medicai IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) ed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s 2 No certificate 1 🗌 Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 🗷 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide To the Hospitel within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who GAVI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Kling October 2004 10:45 pm 4, Alexandria R. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Essex Riverview Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2XF Director May 3. 212-22-1655 78 1926 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 ie marked other than "netural", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 X No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21221 Funerai Α. filed within 72 hours after death 307 Lorraine Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental 8 int: if item 27 is marked o ဂ Anna Vaselinko Repkorwich Denny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 307 Lorraine Avenue Essex, Maryland 21221 William L. Kling (Husband) 20a. Method of Disposition

✓ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10/8 2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery Baltimore, Maryland 21. Signal in Africa 20 lice Licensee permit. 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue Home PA Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ov/cinear disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner almic Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 H Frent Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month -Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi funeral of 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by determined 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and the offcertifier 29c. License number 29d. Date signed (Month, Day, Year) MO 0 005517 6 104 SEAASTIAN NITA 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASTERS MENUE 21224 BALTIMORE MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 8 2004

DHMH 17 Rev 1/2001

Registrar

OCT 0 8 2004

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Sue D. Lewis 2004 Oct /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Egle Nursing Home Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 220-16-3946 **Director** 94 July 5, 1910West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ira Madical Examinatings the notified at Be Completed by Funeral Director 1 ☐ Yes 2√2 No Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Deer Run Court Apt D, 21227 USA Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
and of Health and Mental Hygiene.
and: if item 27 is marked other than "netural", or Items 23.
ury or other fraumatic event, it a Maclical Exertination. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 12 <u>Education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) J. Fred Dillon Lettie Dando 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Ann Lewis-Daughter 20 Deer Run Court AptD, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Oc. 5, 2004 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Frostburg Memorial Park 1 4 ☐ Donation 5 ☐ Other (Specify) Frostburg, 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metaboli Physician encepha 3 Wreak /Medical Due to (or as a consequence of) Examiner Jemen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed after death. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral of 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

naral Diractor: A
filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10.05-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD 21532 S.L. SANOHII 48 Tarn Terrace 31. Date filed (Mooth Day, Year) OCT 0 8 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day **Physician** SEPT 200°4 8:15 HARRY LEWIS Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11015 WASHINGTON HOLLOW ROAD ALLEGANY FROSTBURG If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, MAY 19 **Funeral** 9. Birthplace (State or Foreign Days 1**X** M 2□ F MARYLAND Director 220 30 7999 71 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ral', or items 23a or 28a-f ehov Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11015 WASHINGTON HOLLOW ROAD 21532 U.S. filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 N Yes 2 No KOREAN If Yes, Give Year or Dates: CONFLICT 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced WHITE 'natural' The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than Irry or othar traumatic event, Itia M. Elementary/Secondary (0-12) College (1-4or 5+) 10 CONDUCTOR RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN W. LEWIS ANNIE WHITE ပို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11015 WASHINGTON HOLLOW ROAD, FROSTBURG, MD 21532 BETTY NORTHCRAFT / COMPANION 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State THE CUMBERLAND CREMATORY 9/28/04 CUMBERLAND, MD Important: I eny injury o once. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN ST. 7/42 1600 CB M00547 SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be Unknown 3 Probably 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only or 25 No Hospital: Other: 4 Nursing Home 1 Tyes 1 🗌 tnpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of Math 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After s after december of Director: After 5 Pending investigation 1 TYes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Homicide 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the the 29b. Signatule and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) tho completed cause of death (ttem 23a) (Type, Print) H ROBERT E. RAPP, M.D., BRADDOCK MEDICAL GROUP, 912 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia /Medic		Katherine Larson October 5 2004 8:00am
	Examin		4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth
			1201 Middleway Rd Apt. 3D Middle River Baltimore
	Funeral Director		5. Social Security Number 212-20-5900 6. Sex 7. Age (In yrs. lest birthday) 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/29/1925 9. Birthplace (State or Foreign MD) 9. Birthplace (State or Foreign MD) 9. Birthplace (State or Foreign MD) 9. Birthplace (State or Foreign MD) 1 Months Days Hours Min. 8/29/1925
	p ,		Usuel Residence of Decedent
	anyla.	_	10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits 10d Insi
	he M	90	
	23a or	rai Dir	10e. Street end Number 1201 Middleway Rd Apt 3D 10f. Zip Code 21220 USA
920	d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiana. 7 is marked other than "natural", or frems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: 14. Race - American Indian, Black, White, etc.
2-0	72 ho	Se l	15. Decedent's Education 16e. Decedent's Usual Occupation 16b. Kind of Rusiness/Industry
21		현	Elementary/Secondary (0-12) College (1-4or 5+)
12	led w lygiar h, th	Be Completed	8 0 Homemaker Own Home
and	2 should be filed with and Mental Hygians Is marked other than raumatic event, tre.	9 Be	17. Fether's Neme (First, Middle, Last) Adam Kuhn 18. Mother's Name (First, Middle, Maiden Sumame) Mary Draly
Z Z	should and Men marke	2	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ž	alth a 27 la r trac		Joseph P. Kuhn, Brother 17 Glade Ave Balto., MD 21236
ore,	of Health of Health I Itam 27 I		20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
Ĕ	Page net: if		1 Burial 2XCremetion 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 10-6-04 Baltimore MD
Baitimore, Maryland 21215-0036	permit. Pages Dapartment of Important: If It any Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale FuneralHome 1211 Chesaco Ave Rosedale MD 21237
			23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) e. Adeno carcino ma of the Cong Due to (or as e consequence of):
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ς,	be axecuted siclan and burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as e consequence of): Due to (or as a consequence of):
68760,	cata be a physiclan s the buria	edicai	Ceuse (Disease or injury that initiated events Due to (or as a consequence of):
	d ph as th	8	resulting in death) Last
Вох	eath certifl ettending	ar/	d
-	the et	Sici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
P.0	requires that the death certificate be assocuted even signed by the ettending physician and hould be datached for use as the burial-transit	Completed by Physician/M	Chronic intermittent as pirohan from Suallowing 18 Yes 20 No 30 Probably 40 Unknown
Vital Records,	signed d be date	ا <u>ۋ</u>	
Ö		e e	Asstruction Secondary to addication to layred Concar performed? available prior to completion of cause
Re	sician: The law certificate has b lirector, page 2 s	E	Mitra / While regure to trans Aortic stenosis 10 yes 20 No 10 yes 20 No
tai	ifficate or, pe		25. Wes case referred to medical 26. Plece of Death (Check only one)
>	Physician: r this certific rel director,	To Be	examiner? 1 Yes 2 No
ō	g Physical dispersion		27. Menner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
Ö	Attending ir death. actor: After by the fune	atic	2 Accident investigation M 1 Yes 2 No
Division of	or Atte	Sertific	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	edicai Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.
	To the transfer of the transfe		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	/		▶ Bistin M Clark, MD D53966 10-5-04
- 1	h		30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Krishin MClark
\	.)		9101 Franklin Square Dive Svite 205 Baltimore, MD 21237
1	Stat	е .	31. Dete filed (Month, Day, Year) OCT 0 8 2004 32. Registrer's Signature

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Catherine E. Messick SEPTEMBER 26 2004 10:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND MEMORIAL HOSPITAL ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 30, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Months 1 ☐ M 2 💢 F **1**928 MD 212-24-1128 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Items 23a or 28e-f show the Wedled Evantiner must be notified at Cumberland MD Allegany 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 623 Quebec Avenue USA by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene, Important: If item 27 is marked other than "naturel", or then any injury or other transmits. 1 Never Married 2 Married Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George E. Thomas Oleta V. Forbeck Thomas ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 623 Quebec Avenue husband Cumberland James Messick MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hermon Cemetery 9/28/2004 MD Cumberland 4 □ Donation 5 □ Other (Specify) ure of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Etter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIAC ARRHYTHMIA HOURS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of). Examiner NVE burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSON'S, HYPERTENSION, PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPOTHYROID, CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a Was an CAUDA EQUINA SYNDROME 1 Yes 2 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054411 SEPTEMBER 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 BEVERLY CALKINS, M.D., 500 MEMORIAL AVE., CUMBERLAND, MD 31, Date filed (Month, Day, Year) 7CT 0 8 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 7. Age (In yrs last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Hours 37-28-080: Director North Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "naturel", or Items 23a or 28a-f show treumetic event, the Medical Exercities in minister collided at 1X Yes 2 □ No Maryland Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 her 21 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 2 X No 1 ☐ Never Married 2 ☑ Married Yes 1 ☐ Yes 2 🕱 No Maryland 21215-0036 Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Heae (1-4or 5+) Elementary/Şecondary (0-12) raci 02 and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moore nse annie 19a. Informant's N e/Relationship (Type, Print) (with 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Sher. other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2004 0 National 101 Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service License 22. Name and Address of Facility Home W. North Ave. Balto, Ma. 21216 Funeral 23a. Part Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Immediath Cause (Final disease or condition resulting in death)

a. WWW Of ME ROSTAL WITH LINE METACOR RESULTING TO THE ROSTAL WITH LINE METACOR. Approximate Interval Between Onset and Death CLUCER OF THE PROSPATE WITH BONE METASTASIS **Physician** YEKRS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ENSION 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy 2.00 No Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 2 3 DOA s after dec. this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a
To the Funerel C filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760, To the Hospitel or

> State Registrar

31. Date filed (Month, Day, Year) OCT 0 8 2004

JUMAMOY.

smann MI

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

PA 32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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7	Exami		4	a. Facility Name (If not institution, give street ar	1	4b. City, Town, or Location of Death		4c. County of Death	
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	Director			212-40-2878 1× M 20	F 65 Yrs.	Months Dave Hours Min	8. Date of Birth (Month, Day, Yea 5-31-30	A MA	RY AND
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	or 28s	Olrec	1	0e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
	sath w	ral	_	133 Elinor A	Ive.	21236		USA.	
(0	r Item	Fune	1	1 Never Married 2 Married 1 1 X	Yes 2 No	 Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F 	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
003	72 hours after death with the Maryland natural", or Items 23a or 28a-1 show Steal Examinan must be notified at	dby		If/Ye	es, Give r or Dates:	1 ☐ Yes 2 🗖 No Specify:		Specify:	hite.
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Ma	nd 2 sl Ith and 27 Is r r traur			9a Informant's Name/Relationship (Type, Prin	Driend 200	illing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip	Code)
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Baltimore,	Pagiment ant: It			1 ☐ Buria 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Gardens	of Faith Concepy 10-	7-04 R	sedale	MO.
Ball	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once.		2	11. Signature of Funeral Service Licensee	100/10	22. Name and Address of Facility	LTIMORE	mo 212	34.
			1	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one gause	that caused the death. Do not e	VAND FUNGRACCH enter the mode of dying, such as cardiac or	respiratory arrest.	O HARTOR	Approximate
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	10		اک	D. Name and address of person who completed	cause of death (frem 23a) (Type	a, mint)	6601 N	. Charles	Street
	Sta		3		32. Registrar's Signature	1	To	wson, Md.	21204
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October 4,2004

Joseph Mueller

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Division of the Hospital or Attendithin 24 hours after death of the Funeral Director; completely filled in by the 1 Medical Certificat		Could not be determined Certifying Phy Medical Exami	building sician: To the b	g, etc. (Specification) est of my knotists of examina	y) wledge death	occurred a estigation,	it the time	nion, death o	lace and	City or Town	n, State) ause(s) a late and p	and manno place, and	er as stat d due to th	ed. 1e cause(s)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Edith Bertha Manner Octobel 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner County of Death Franklin Square oseda enter more 6. Sex Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 219 18 0630 1 □ M 2 1 F 79 Director July 29,1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 No Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3539 Buckboard Lane 23a 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be and Mental John O. Morton Julia J. Gillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tre Eugene G. Manner (Husband) 3539 Buckboard Lane Baltimore, Md. 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 10/6/2004 Bayview Crematory Baltimore, Maryland permit. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23 Part. Enter the disease, or complications that caused the death, strock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ard /Medical Due to (or as a consequence of) **Examiner** 5: Sequentially list conditions, any, be included an addata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or is a consequence of): Examine the death certificate be executed 1 ١ı ue to (or as a consequence of): buriatattending physician Physician/Medical the as IF FEMALE: 980 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month 4☐Pregnant at time of death 5 Other (specify) P.O. the detached Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobageo use contribute to the cause of death? þ 1 es 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate Vital 1 ☐ Yes 2 No 1 Yes 2 🗆 No Physicien; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2 1 🗌 Yes 2 TIN 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of After this 28a. Date of Injury (Month, Day Year) 27. Manne f Deat Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Injury atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune completely f 2 Medical Examiner: 2h the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur 29c. License number ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year DCTOBER 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOR BALTIMURE REHABILITATION EXTENDED CARE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 11,1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 ☐ F Director 216-16-8869 80 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 1 Yes 2X No Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1946 Holborn Road 21222 United States death y Funeral Iteme: 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 No WWII
If Yes, Give
Year or Dates: 1943-46 1 ☐ Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "na any injury or other treumatic event. Ite Media ones. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Meterman Refinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William G. Meyers Edith Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eileen E. Meyers / Wife 1946 Holborn Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 10/8/2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee Dundalk, Maryland 7922 Wise Ave. 233 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER COLON Physician 3 year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. I the ۾ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Quinknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 🗌 Yəs 2 No 1 TYAS 2[] No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: P 1 ☐ Yes _2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) eral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide To the Hospitel 29a. Certifier i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA 3900 LUCH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Physici /Medic		Decedent's Name (First, Middle, Last	Jacquel	ine	Nicho	ls				2. Date of Deal	Day OA	2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Washington Coun				Ha	ager	Location of				ty of Death hington	
	Funeral Director		5. Social Security Number 6. S 177-42-3158 1 Usual Residence of Decedent	x 7. Ag	54	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) June 11	1950	9. Birthpla Count Mary	ce (State or Foreign Y) Land
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show any highly or other traumatic avent. In a Medical Examinating must be notified at ance.	Funeral Director	10a. State 10b. County Penna. Frankli 10e. Street and Number	n		y, Town or Lo Vaynesl		Code			1	Og. Citizen of	10 What Countr	d. Inside City Limits 1 ☐ Yes 2 1 No
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9200	ours after de ral', or Itams Examinar n	Ď	11. Marital Status 1 Never Married 2 💢 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 Yes 2 1 If Yes, Give Year or Dates:		1	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar <i>Specify:</i>	gin? (Spo n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ace - America ack, White, et ify: Whit	tc.
21215-0036	filed within 72 h Hygiene. Ither than "netu ont, Ina Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		5+)	(Give	dent's Usua kind of wor DO NOT us nsed I	rk done o se retired,	luring mos)		ing		Business/Indu	
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P.O. Box 68	the death certifi by the attending ached for use as	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pro						ate of delivery onth D	r Year
rds, F	w requires tha been signed should be det	þ	Part II. Other significant conditions of	intributing to death b	ut not res	ulting in the u	nderlying ca	ause give	n in Part I.					cause of death?
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	Jing After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		Bc. Injury Work	at ? 'es 2 🗆	- 1	28d. Describe ho			
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	To the Hospital within 24 hours a To the Funaral i completely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	vsician: To the best iner: On the basis o and manner st	f examina	wledge, deatl tion and/or in	occurred avestigation,	in my op	e, date an inion, dea	d place, a th occurre	and due to the ca ed at the time, da	use(s) and m te and place,	anner as state and due to th	ed. ne cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Ottinger September 30, Dorothy Anna 2004 10:35 AM. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Center Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, July 4, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 □ F 89 169-14-2965 Director Penrisylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1√Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 30 North Place 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ۵ Specify: 3 Nidowed 4 Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) Cafateria Manager School System ith and Mental Hyc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Granville Rambo unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any injury or other trau John W. Ottinger/Son 6102 River View Court, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Method of Disposition

1XD Burial 2 Cremation 3 Removal from State Brownsville Heights Cemetery Oct. 4, 2004 Brownsville,

4 Donation 5 Other (Specify) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Keeney and Basford Funeral Home 100021 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY **ARTERY** DISEASE /Medical Due to (or as a consequence of) Examiner MYO CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner CONCIESTIVE and that initiated events resulting in death) Last physician as Due to (or as a consequence of): Box 68760, Physiclan/Medical as the attending IF FEMALE esn esn 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy ţōţ in the past 12 months? Month Vear Day 5 Other (specify) P.O. I detached ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe ULCER 4 Donknown 2 🗆 No 3 Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed' certificate 1 ☐ Yes 2 1 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. investigation 1 ☐ Yes 2 PNo 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) I in by 1 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Vithin 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47951 7) 00 > llazon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE AVE. FREDERICK. MD 814 A. KAZMI 32. Registra s Signature State TO 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

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	Funeral Director		5. Social Security Nu 213-03-942	29 ¹	ex □ M 2 X F	7. Age (In yrs 89	s. lest birthday) Yrs.	If Under Months	r 1 Year Deys	If Under 24 H Hours Mi		irth <i>Pay, Year)</i> 29 , 191	9. Birthp Cour 5 Mary	olace (State otry) yland	or Foreign
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			MARCIA G 31. Dete filed (Month,		32 Rec	sistrar's Sign.	ature -		2 B	12 CADIO	ills mi	>			
	State Registra	-		T 0 8 200		har A	K Lu	Me							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year PONG UN 16.592 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL COLVM BIA HowAren HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 568-91-5112 Director KOREA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28e-1 show the Medical Examinar must be notified at 10d. Inside City Limits Director HARFOR 1 Yes 2 No HAVRE 10e. Street and Number 10g. Citizen of What Country? 1100 10N 21078 KOREA 14. Race - American Indian, by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No f Yes, Give fear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: KOREAN Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. nomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental KUN ONO 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/078. permit. Pages 1 and 2: Department of Health ar Importent: If item 27 is any injury or other trau once. Havre rak 1100 KEVOLUTION de ากด 20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNCTURE CHAPTE 10-6-04 20a. Method of Disposition 20c. Location -1 ☐ Burial 2 A Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) FORESTHILL ME 21. Signature of Funeral Service Licens 22. Name and Address of Facility FOREST HILL, MD 21050 Simber EVANS FUNERAL CHAPEL-BELAIR, 3 NEWART DR 23a. Part 1. Enter the disease, of complications that cause the yeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART **Physician** /Medical Due to (or as a consequence of): Examiner DEMENTIA ALZHEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit DEGENERATIVE 1 SINT Due to (or as a consequence of) Physiclan/Medical use as the attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by OF SPINE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No cate has page 2 s 24a. Was an autopsy performed? certificate 1□ Yes 2☑No of Vital or Attending Physicien: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PRIMARY CARE DO056948 10 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOLPHN 2ALT UMORE ANS LMD A 5-22 SMOTET F1515 OM 31. Date filed (Month, Day, Year) OCT 0 8 32. Registrat's Signature State Registrar

		State of Maryland / Departm	ent of Health and Me cate of Death		ene	31890
		Registrer 1. Decedent's Name (First, Middle, Last)		2. Date of Death	37, 37, 4	3. Time of Death
Physicia		George Henry Plitt		October	4 2004	8:00P.M
/Medic Examin			City, Town, or Location of Death		4c. County of Death	
Camin	Ç!		Ellicott City		Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	nplace (State or Foreign untry)
Director		213-09-5642 1\(\overline{A}\)M 2\(\overline{\text{F}}\) 96 Yrs. \(\overline{A}\)	tis Days Hours Will.	(Month, Day, Y July 13,	1908 Mary	land
pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
aryla	-					1 ☐ Yes 2XXXIo
8e-f	Director		ott City f. Zip Code	100	. Citizen of What Co	untni?
with the	늅		21043	100	U.S.A.	unity:
sath v	Funeral	8700 Ridge Road		cify Yes or No-	14. Race - Amer	rican Indian.
ter de	un	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 11. Yes 2 ★ No	Decedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
urs af	by	3 Modowed 4 Divorced If Yes, Give 1 ☐ Yes	es 2⊠ No Specify:		Specify: Wh	ite
72 hours after death with the Maryland natural, or items 23e or 28e-f show dical Examinar must be notified at	ted		Usual Occupation of work done during most of workin	16	6b. Kind of Business/I	ndustry
hin 7	ple	(Specify only highest grade completed) (Give kind of life. DO NO	OT use retired)			
ad wil	Completed	12 Manager			acking Mal	ker
d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name			
Men Men arke	L _O	George Henry Plitt		ne Casse		
2 sh and is m			dress (Street and Number or Rural oon Overlook Woo			
1 and 1 and 1 ealth im 27 ther t		Janice Davis (Daughter) 2120 Tro			c. Location - City or	
in its		1 N Burial 2 Cremation 3 Removal from State	or other place)		,	
t. Partment			Cemetery 10-7-		altimore,	
parmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene and propretty it is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, the Medical Examinat must be notified at once.		Deman Dander 1630	ke Funeral Home Le Edmondson Ave.	of Cato Catonsv	nsville, ille, Mary	Inc. yland 21228
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or	respiratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	disease			Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):				0
Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
VKR 5	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
be executed ician and burial-transit	хап	resulting in death) Last C				
rate be executed only sician and the burial-transit	alE					
physicate s the	adlo	d				
The could us, T.C. BOX 00. The law requires that the death certificate are has been signed by the attending phys age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
atter d for u	ciar	in the past 12 months? 4 Pregnant at time of death 5 Other	pic pregnancy er (specify)		Month	Day Year
oy the achee	hysi	9 Unknown				
law requires that the death cer as been signed by the attendir 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
requires requires leen signs hould be				1 Yes	2 No 3 □ Pro	obably 4 Unknown
aw re	plet			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
VICAL DESIGNATION OF THE PASSES OF THE PASSE	Completed			performe	death? XNo 1 ☐ Yes	2□ No
lcian: certifica ector, p	Be	25. Was case referred to medical examiner?	26. Place of Death			
Physic Physic this ce	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3			ce 6 □Other (Spec	cify)
ng Pl	on:	27. Manner of Death 1 ★Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how	injury occurred	
Attanding at death. ector: Afte by the fune	catl	2 Accident investigation		06 1 (61		-10
or Att	ertification;	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office 2	City or Town,	et and Number or Ru State)	rai Houre Number,
urs a	O	29a. Certifier 1 € Certifying Physician: To the best of my knowledge, death occu	and at the time, date and along a	and due to the ani	uso(s) and manner as	stated
To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) (Check one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check o				
To the within To the compli	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	n, Day, Year)
. , , ,		Jone Must in	D0059914	0	etober 6	Yeas
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
2			load Baltimore	MD :	21228	
Sta Regist		31. Date filed (Month, Day Year) 8 2004 32. Registrar's Signature	sports			
41541631	CII.		*			

1- For Unpend Item	23a, pt. 11, 27, 28	J/Depa Sa-I-P	rtment er me tificate	6836	alth ai	26-64r	ntal Hygi tas	ene	11.	1501	
1. Decedent's Name (First, Middle, L.						2.	Date of Death	Day	Year	3. Time of Death	
Barry Ra 4a. Facility Name (If not institution, gi	4b. City, Town, or Location of Death			September 29,							
	be fighed hoop to							<u> </u>	9 Birthplace (State or Foreign		
		Yrs.				Min.	(Month, Day,	1957		Birthplace (State or Foreig Country)	
10a. State 10b. County	,								100	I. Inside City Limits	
MD 10e. Street and Number	В	аттшк		ode			10	g. Citizen of V	What Countr		
1501 Desoto Road				2123	0			USA			
3 ☐ Widowed 4 X Divorced	Armed Forces? 1 XYes 2 No 1981	-84				in? (Specify Puerto Ric	y Yes or No- an, etc.)	Blad	k, White, et	C.	
15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give life. i	kind of work OO NOT use	done du	ion ring most	of working		Air C	onditi	oning &	
	t)	IIVA		1	8. Mother	's Name (F				501,100	
Lester Lee Ral	-										
								-	_	ode)	
20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	ace of Dispo	sition (Name natory or oth	of er place)		Date	2	0c. Location -	City or Tow		
		Ga Ga	Name and	Address Kau	of Facility Éman	Funer	ral Hom	e@Mea	dowrid		
23a. Part1. Enter the disease, or co- shock, or heart failure. List on	implications that caused the death. If you cause on each line.	. Do not ent	er the mode	of dying,	such as c	ardiac or re	espiratory arre	st,	1	approximate nterval Between	
Immediate Cause (Final disease or condition	aChlordiazepo	oxide								Inset and Death	
	Due to (or as a consequ	ence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
	Due to (or as a consequent of d.	ence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal	death 3[ay Year	
Part II. Other significant conditions Hypertensive arte	_	-		-						cause of death?	
				_			autopsy perform	red?	prior to comp death?	y findings available detion of cause of	
25. Was case referred to medical examiner?	Hospital:			Other				-			
	1 Inpatient 2 8	28b. Time o		-	4 🔲 INUI:						
1 Natural 5 Pending 2 Accident investigati	on 9-29-04										
4 Homicide determine	d 286. Place of Injury - At hol	me, farm, sti	eet, factory,	office					Di Des	oto Kd.	
	Physicien: To the best of my know					place, and	due to the ca	use(s) and ma			
29b. Signature and title of certifier	em		29c.								
30. Name and address of person wh	completed cause of death (Item	23а) (Туре,	Print) 111	Pen	n Sti	reet,	Baltim	ore, M	aryla	nd 21201	
31. Date filed (Month, Day, Year) OCT 0 8 20		erure A	N/								
	1. Decedent's Name (First, Middle, La Barry Ra 4a. Facility Name (If not institution, git St. Agnes Hos 5. Social Security Number 6.: 464-17-9917 Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 1501 Desoto Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest git Specify onl	Decedent's Name (First, Middle, Last) Barry Raley Raley	Rarry Raley Raley	Rarry Raley Raley	1. Decodent's Name (First, Middle, Last) Rancy Raley R	1. Decedent's Name (Frest, Microbe, Last) Barry Raley Raley Race Race St. Agnes Hospital St. Agnes	1. Decedent's Name (First, Middle, Last) St. Agnes Hospital S. Social Security Number 6. Sec 1/2 M 2 F 7. Age (in yrs. Nat birthday) Baltimore S. Social Security Number 6. Sec 1/2 M 2 F 7. Age (in yrs. Nat birthday) Baltimore S. Social Security Number S. Sec 1/2 M 2 F 7. Age (in yrs. Nat birthday) Baltimore S. Social Security Number S. Sec 1/2 M 2 F 7. Age (in yrs. Nat birthday) Baltimore S. Social Security Number S. Sec 1/2 M 2 F 47 Yrs. Sec Sec 1/2 M 2 F 47 Yrs. Sec Sec 1/2 M 2 F 1/2 M 2	2. Date of Death September	BAITY 4s Facily Name (**Fort Mode), Last) St. Agnes Hospital 5. Social Security Name (**Fort Name (**Fort Name of Name	December Name (Part, Motobs, Last) Barry Raley 4s. Pacily Name of Commence of the desirable of the d	

			1 - For State Registrar	State of M	•	partment of t ertificate of		and Mental Hyg	iene		31892	
	Physici		1. Decedent's Name (First, Middle, Las	1)				2. Date of Deat Month	h Day	Year	3. Time of Death	
	/Medic		Dorothy Ried	October	5	2004	3:10A M					
7	Examir	ier	4a. Facility Name (If not institution, give)	4b. City, Town, o		of Death	4c. County	of Death		
			Joseph Richey Ho		ge (In yrs. last birthda	Baltin		24 Hrs. 8. Date of Birth		O Dinha	lane (Chate on Freedom	
	Funeral Director		5. Social Security Number 6. S 215-07-5191	M 21⊠F	99 (111 yrs. last birtilda 84 Yrs.	Months Days	Hours	Min. (Month, Day, Nov. 17,	Year) 1919	Coun	lace (State or Foreign try) Land	
			Usual Residence of Decedent		0 1		1	100. 179	1717	Hary	Tand	
	yland		10a. State 10b. County		10c. City, Town or	Location		,		1	Od. Inside City Limits	
	Ra-1 s	cto	Maryland Baltim	ore	Cat	consville					1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of	What Coun	try?	
	ath w	ā	407 Maiden Choic		5	2122				.S.A.		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygene Is marked other then "neturel", or Items 23e or 28s-1 show aumatic event. Its Musical Examinating and the Hygene	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	?	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)		e - Americ ck, White, v:		
21215-0036	2 hou	ted	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occup ve kind of work done	ation	a d working	16b. Kind of B			
215	thin 7	npie	(Specify only highest gra	College (1-4or	5+)	DO NOT use retire	d)	of working				
2	ed wi	Sol	12			Bookkeeper		(5)	Const		on	
Maryland	be fil ntal H od oth	Be	17. Father's Name (First, Middle, Last)					r's Name <i>(First, Middle, N</i>		ne)		
7	hould d Mer marke maric	2	George Spence 19a. Informant's Name/Relationship (1)	Type Print)	19h Me	iling Address (Street		zabeth Einsc er or Rural Route Number,		State Zin	Codel	
Z	d 2 s th an t7 ls i traui		Eugene S. Rieder	(Husband				Lane Catonsv	_			
	1 and Health tem 27 other tr		20a. Method of Disposition	(IIdsballd		position (Name of rematory or other pla			20c. Location			
JO T	Pages nent of I int: If Its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		•	wn Cemeter	l l	10-7-2004 M	farriot	tevil	le Marulan	
Baltimore,	# 문문를		21. Signature of Figneral Service Licen	-	1	22. Name and Addre	ss of Facility	V				
m	Depar Impo eny ir		Deman	Walls	whil	litzke Fun 630 Edmon	eral H dson A	Home of Cato Ave. Catonsy	nsville ille, l	e, In Maryl	c. and 21228	
	Provided pro	Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		E DISTAC	. CH	RETER			Interval Between Onset and Death CNE 4CM
.O. Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death	B □Ectopic pregnanc: 5 □ Other (specify) □	/		23d. Da Mo	te of delive	ry Day Year	
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000	law requir as been si 2 should	piet	REFLIX DISESSE; H	GIERTONSIN	W; Hx of	VEHILEGIN	74 DL	24a. Was an autopsy		Were autop	osy findings available appletion of cause of	
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isio	Attending r death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm,		Yes 2 1	28f. Location (Str.	eet and Numb	er or Rural	Route Number	
Division	for Attendated after death Director:	Certification:	4 Homicide determined	building, e	tc. (Specify)	street, lactory, office		City or Town,		0, 0, 1,0,0,	Troute rumber,	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h, completely filled in by the funeral director, page	edicai C			of examination and/or			l d place, and due to the ca h occurred at the time, da				
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	i (Month, E	Jay, Year)	
			Im Juna	nn		1000	2248	8	OCT.	5,2	ocil.	
-	М		30. Name and advess of person who									
_	11		L.M. JUMAMOY,	M.D.P.		UNBRIDGO	PORD	; BACTIMOR	E, Me	0.2,	12/2	
•••	Sta Registi		31. Date filed (Month, Day, Year)		tracis Signature	& Sp	als					

3:10 AM

DOROTHLY RIEDER 10/5/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Justin Michael Shay 5:27 P^M September 29 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7 Sunny Dell Drive Elkton Cecil 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Oay, Year) Birthplace (State or Foreign Country) Hours 12 M 2□F Months Director Yrs. 222-80-6776 March 25, 1990 California Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 28e-f show 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examiner mast be natified at Director 1 ☐ Yes 2 No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sunny Dell Drive 21921 Completed by Funeral United States filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filled within ment of Heelth and Mental Hygiene. ant: If item 27 Is marked other than ury or other traumetic event. Ithe Ms. Elementary/Secondary (0-12) College (1-4or 5+) Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ David Michael Shay, II Colleen Igo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Igo/Mother 7 Sunny Dell Drive, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of October 5, 20c. Location - City or Town, State Delaware Veterans 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Memorial Cemetery Bear, Delaware 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anging /Medical Due to (or as a pursequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisace or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, <- or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 XNO Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an certificate has performed? 1 XYes 2□No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) At Scene this 28a. Date of Injury
Found, Day Year)
Found 9 29104 LINE NOWY 27. Manner of Death After 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 Yes 2 No Subject hanged self nours after death neral Director: / filled in by the f 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Govage of veside wel 281. Location Street and Number or Rural Route Number, City or Town, State) 7 Sunny Dell Dr. Garage within 24 hours a To the Funeral L Elkiton, MD Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** September 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

			For State Registrar	State of M	laryland	-	artment of H rtificate of L		and M		giene Reg. No.	004	3 : 8 9 1-									
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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland /	Department of Health and N Certificate of Death	Mental Hygien	2001. 21000
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	E Autili		St. Agnes Health care Baltimore			/A
	Funeral Director		5. Social Seculity Number 6. Sex 101 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 15,	Year) 1943	D. Birthplace (State or Foreign Country) Pennsylvania
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	or 28e	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	at Country?
	ath wil	rai	1543 South Rolling Road 21227		United S	
036	2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. is marked other than "natural", or Items 23a or 28e-f show eumatic event, the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: 1) Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
215-0036	72 ho natur	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	king	6b. Kind of Busin	ness/Industry
2121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) 12 Dispatcher		Alarm S	Systems
Jd 2	be filed Ital Hygi of other	BeC		ne (First, Middle, M		
<u>ya</u>	ould b Ments varked	To		Barletta		
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Elaine Seran Wife 19b. Mailing Address (Street and Number or Ru 1543 S. Rolling Rd., I		•	ate, Zip Code)
	os 1 an of Heal Item 2		20a. Method of Disposition 20b. Place of Disposition (Name of			ty or Town, State
Baltimore,	Page ment cont: If ury or	1	Donation 5 Other (Specify) Bayview Crematory, Inc. 10-		Baltimo	
Balt	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any Injury or other tre	(21. Sur res of Funeral Service Licensee 22. Name and Address of Facility And 1328 Sulphur Spring	g Rd., Ar	butus, N	•
•	Pnysician /Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence or).	^		Approximate Interval Between Onset and Death ZO YEUY
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ificate be executed g physician and as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		-1-	
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of Month	,
Cords, P	uires that the de signed by the a d be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba		te to the cause of death? Probably 4 []Unknown
5	aw require s been sig 2 should t	Completed	Lung Cancer	24a. Was an	24b. We	re autopsy findings available
S I Re		Com	Aorthe Stenosis	autopsy perform 1 ☐ Yes 2	eg? dea	or to completion of cause of uth? I Yes 2 \sum No
(M)	Physiclan: The this certificate hiral director, page	Be	examiner?	th (Check only one		
9 6	Phys rahis ral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Resider		
(Λ) ,	Attending F r death. sctor: After by the funer	atio	2 Accident investigation M 1 Yes 2 No			
aran Divisio	after de Directo	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,		or Rural Route Number,
Sc	To the Hospitel or Attentwithin 24 hours after dealt To the Funerel Director: completely filled in by the	Medicai C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	, and due to the car rred at the time, da	use(s) and mann te and place, and	er as stated. If due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and the of certifier 29c. License number	29	d. Date signed (I	Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5 0	1040 per	5,2004
	6		30. Name and address of person who completed cause of death (Item 234) (Type, Print) St. Hyws Home to Ball Ball Type, Print)	L. Fr	yden	ban
F	Sta Registr		31. Date filed (Month) Day, Year) OCT 0 8 2004 32. Relistrar's Signature,	•	/	

RJ 04-06444 George A. Stallings, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	For State Registrar	State of Ma	aryland		artment of H tificate of I			giene _{Reg. No.} ()	Λ.	21202
			Decedent's Name (First, Middle, Las	1)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		George A. Stallin						Octobe	r 6, 2	004	12:40 A.M
7	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. Co	unty of Death	
			University of Mary				Balti					
I	Funeral Director		215-22-06/4	x 7. Age 7. Age 7. 77	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Date of Bird) (Month, Date of Bird)		9. Birthp Cour Mary1	place (State or Foreign ntry) and
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mar Mar Mised	ţo	MD		Bal:	timore						1 Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	th will		1340 James Street				21223			U.S.A	١.	
	dea ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp. Mexican, Puerto	ecify Yes or No	- 14.	Race - Americ Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "neturel; or Items 23a or 28e-f show svent, the Medical Examinating be notilized.	þ	1 ☐ Never Married 2 ♣ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑↑ If Yes, Give Year or Dates:	No	İ	1□Yes 2⊠No	Specify:	, , , , , , , , , , , , , , , , , , , ,	1	ecity: Whit	
2-0	72 hc	ted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	tent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work	cina .	16b. Kind	of Business/In	dustry
21	thin e.	Completed	Elementary/Secondary (0-12)	College (1-4or 5)	9			
2	filed withi Hygiene. other than	S	8			Truck	Driver			Freig		
Maryland	2 should be filed v and Mental Hygie is marked other t reumatic svent, ID	o Be	17. Father's Name (First, Middle, Last) George A. Stallin	gs, Sr.				18. Mother's Nam Agnes Ba		Maiden Sur	name)	
ary	s 1 and 2 should I I Health and Meni Item 27 is marke other treumatics	_X	19a. Informant's Name/Relationship (7	уре, Print)		19b. Mailir	ng Address (Street a	and Number or Rui	ral Route Numbe	er, City or To	wn, State, Zip	Code)
	12 a Z		Jenny M. Stalling	s/Wife		1340	James St	reet Balt	imore,	Md 21:	223	
Baltimore,		- "	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	θ)	Date	20c. Locati	on - City or To	own, State
Ĕ	permit. Pages Department of I importent: If it any injury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Ho1	y Rede	emer	10-0	9-2004	Baltin	nore	
ati	mit. Parpartmen sortent: / injury		21. Signatur of Funeral service Licen	ton Man			Name and Address					
m	permi Depar impo any ir once.		Will Do	Mellige	,		.mbrose ri .328 Sulpl	nneral Ho nur Sprin	ome, inc ng Rd. A	rbutus	s. MD 2	1227
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death.						1	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	4	4	in 1	Huo 10	lita	Cost	3	1. 1	Onset and Death
1	/Medical		resulting in death)	a. Due (or as	conseque			June C	Carco		~~~	, ,,,,,,
	Examiner		Sequentially list conditions,	b								
	D =	ner	cause (Disease or injury	Due to (or as	а сопвиции	ince of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
90,	oe ex		rooding in doday Eddi	Due to (or as	a conseque	ance oi):						
68760,	ificate be executed g physician and as the burial-transit	edical		d				 				
_	± 0 €		IF FEMALE:	23c. If yes, outcome	of pregnan	cv				224	D /	Name of the last o
Вох	eath cert attendin for use	ian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal o	death 3	Ectopic pregnancy Other (specify)			230.	Date of delive Month	Day Year
o.	res that the de signed by the a be detached t	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		0_						
σ.	that led by deta	y P	Part II. Other significant conditions of	ontributing to death b	ut not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use	contribute to the	ne cause of death?
ds,	uires sigr	d by							101	/es 2□N	o 3□Prob	ably 4 Unknown
of Vital Records,	The law requires that the death cert ate has been signed by the attendin bage 2 should be detached for use :	Completed							24a. Was	an 2	b. Were auto	psy findings available
Re	The lav	m _o							autop	rmed?	prior to cor death?	psy findings available mpletion of cause of
ā		Ö	25. Was case referred to medical					26. Place of Deat	1 Yes		1 Yes	2 □ No
5	Physician: this certific ral director,	To B	examiner? 1 ∰Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 21√2 E	R/Outpatien	t 3 DOA Othe	25	ome 5 Resid		Other (Specifi	()
	g Phys er this eral di		27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of	28c, Injury	at	28d. Describe h			,
ion	nding th. :: Afte	atto	1 Natural 5 ☐ Pending investigation		y 16a1)	Injury	Wori M 1 □ '	Yes 2 □ No				
Division	Attending ir death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	288. Flace of Inju	ury - At hon	ne, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and No	umber or Rura	l Route Number,
Ö	el or s afte of Dir	Certification:	4 🗆 Morricide	building, et	c. (Specify)				Only or Tor	in, State)		
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral.	Medical (ysician: To the best iner: On the basis of and manner sta	examination							
	o the	Me	29b. Signature and title of certifier	1/			29c. License	number		29d. Date si	gned (Month,	Day, Year)
	r ≤ F ŏ		100	1/1/2	A		OCME			Octob	2070	2004
,			30. Name and address of person who of	completed cause of d	eath (Item	23a) (Type,				OCLOR	per 6,	2004
	4		THEWARE	11 King		111	Penn St	reet, Bal	Ltimore,	Mary.	Land 21	201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reportra	ar's Signatu	ire .	1					
	Registi		OCT 0.8	2004	we.	K 1	Coule					

уБ	torrien	y er	For Unpend Item	235tate 028	ar¥land./	Depa Cen	1836 ⁿ tificate	10 ⁶ 1 e of L	gally, a Death	apg Me	ental Hy	giene	The second secon	31000
			1. Decedent's Name (First, Middle, L								2. Date of De	100	Year	3. Time of Death
	Physici /Medio		Joy Lee Sto	ttlemyer								nber 2		4 1510 p ^M
)	Examin		4a. Facility Name (If not institution, gi				-		Location o	of Death			ounty of Death shingto	n
_			Washington Count					erst						
2	Funeral		5. Social Security Number 6. 214-76-0255	Sex 7. A 1 ☐ M 2 ☑ F	ge (In yrs. last b 43	Yrs.	If Under Months	Days	If Under:	Min.	8. Date of Birt (Month, Da		Coui	
5	Director	-	Usual Residence of Decedent		43						July 7	, 1961	l Mar	yland
	laryland show		10a. State 10b. County		10c. City, To	wn or Loc	ation					-		IOd. Inside City Limits
	the Mar 28a-f st notified	tor	MD Washir	ngton	Hage	ersto	OWD.							tX□Yes 2□No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Madical Examitrational be inclified at	Funeral Director	10e. Street and Number 434 North Prospec	ct Street			10f. Zip	Code 1740				10g. Citizer USA	of What Cou	ntry?
	ems a	ner	11. Marital Status	12. Was Decedent		13. W	Vas Deced Yes, spec	ient of His	spanic Orig	gin? (Spec	cify Yes or No lican, etc.)	- 14.	Race - Ameri Black, White,	
36	s afte	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give			☐ Yes 2		Specify:				ecify: Whi	.te
0	72 hours "natural",		15. Decedent's I	Year or Dates:		a. Decede	ent's Usua	I Occupa	ition			16b. Kind	of Business/In	dustry
5	in 72	Completed	(Specify only highest g	rade completed)		(Give k	kind of wor OO NOT us	rk done d se retired)	uring mosi	t of workin	9			333
212	d with	E O	Elementary/Secondary (0-12)	College (1-4or	3+)	ŀ	nomem	aker	`			don	mestic	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: if item 27 is marked other than "natur any injury or other traumatic event, the M. alical once.	To Be C	17. Father's Name (First, Middle, Las Robert Gardner	st)							(First, Middle, ine Ga		mame)	
Mary	nd 2 shou lth and M 27 is mar traumat	-	19a. Informant's Name/Relationship Rhoda Stottlemyer				-				Route Number		own, State, Zip 713	Code)
ore,	iges 1 ar		20a. Method of Disposition 1 XBurial 2 Cremation 3	☐Removal from State	•	ery, crem	atory or o	ther place			ate		tion - City or To	
ij	it. Pa intmer intant injury	ŀ	* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Rest I					10/1/				Maryland
Ba	Depa impo any i		S. Mark S	un		160	01 P∈	ennsy	lvan	ia Av	enue H	agerst	eral Ch town MD	21742
	Prrysician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List online Immediate Cause (Final disease or condition resulting in death)	a. Methado		Queti						rrest,		Approximate Interval Between Onset and Death
8760,	cate be executed wax a physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence									
P.O. Box 6	Attending Physicien: The law requires that the death certifics releath. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as the state of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		e of pregnancy 2		Ectopic pr Other (sp					23d	. Date of delive Month	ery Day Year
	quires that the de: n signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to death	but not resulting	in the un	derlying c	ause give	n in Part I.					ne cause of death? pably 4∭Unknown
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ita	ien: rtiffica stor, j	Be C	25. Was case referred to medical examiner?	k. III. III.					26. Place	of Death	(Check only o			
<u>}</u>	nysic nis ce I direc	To	1 Xes 2 No	Hospital: 1 🗌 Inpat		Dutpatient	3 □ DQ	Othe	r: 4□Nu	ırsing Hom	ie 5 ☐ Resid	dence 6	Other (Specif	y)
ion o	nding PI tth. :: After the	atlon:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Inj (Month D Found		Time of	P M	l8c. Injury Work 1 □ Y	at ? ∕es 2 X I		8d. Describe f known	now injury o	ccurred	
Division of Vital	2 4 5	Certification:	3 ☐ Suicide 6 X Could not determine	be 28e. Place of Ir building, e Scene	njury - At home, tc. <i>(Specify)</i>			r, office		21 H	8f. Location (S City or Tow agerst	Street and Nove, State) OWN,	lymber or Rur 35 E. F Md	ranklin
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (Physicien: To the bes eminer: On the basis and manner s	of examination a									
	To th Within To th comp	M	29b. Signature and title of certifier				290	. License		, ,			igned (Month,	
			avel -					С	CME			Septe	amber 3	0, 2004
				1310, ML		ı) (Type, F	^{2rint)} 11	ll Pe	nn St	treet	, Balt	imore,	, Maryl	and 21201
	Sta Regist		31. Date filed (Month, Day, Year)	2004 32. Regis	trar's Signature	A	de	POLL	1				•	

			1- State of Man		artment of Health a		jiene _{eg. No} ? () () (, alann
			Decedent's Name (First, Middle, Last)			2. Date of Deat	th	3. Time of Death
	Physici /Medic		Glen	S	anLwin	Octobe	Pay Ye	04 1:49 A ^M
2	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of D	
I		:	Frederick Memorial Hos		Frederick		1	erick
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (1) 577-52-3802 1 M 2 F 87	In yrs. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth Oct. 2,	1917 9.	Birthplace (State or Foreign Country) Burma
	D .		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Lo	ocation			10d. Inside City Limits
	shov	,	Maryland Frederick	30. Ony, 10.00 01 20	Rocky Ridge			1 ☐ Yes 2X No
	28a-f	ect	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What	t Country?
	Sa or	ā	9423 Longs Mill Rd.		21778		11.5	5.A.
	ms 2	Funeral Director	11 Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - A	American Indian,
20	n 72 hours atter death with the Marylar *natural, or Items 23a or 28a-f show salcal Examirer must by notified at	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	ł	if Yes, specify Cuban, Mexican,	Puerto Rican, etc.)		White, etc. White
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<u> </u>	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)		rocket s	- · ·
V	ygien /gien erth.	Con	Elementary/Secondary (0-12) College (1-4or 5+)	elec	ctrical enginee			systems
	ges 1 and 2 should be filed within 72 hours affer death with the Maryland to Heath and Mental Hygiene. I del Heath and Mental Hygiene. I file m 27 is marked other than 'natural', or items 23a or 28a-f show it the Maylori Examiner must be notified at or other traumatic event, the Maylori Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) George Morris Christoffel	sz		's Name <i>(First, Middle, M</i> 1ae Caroline	•	S
=	A PE		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number	or Rural Route Number	, City or Town, Stat	te, Zip Code)
<u> </u>	and 2 ealth a n 27 is		Glynis Dalgarn/daughter		Longs Mill Rd.		idge, MD	
D C	of He of He if iter				sition (Name of matory or other place)		20c. Location - City	or Town, State
	Pages tment of I tant: If its jury or o		'4 ☐Donation 5 ☐ Other (Specify)		y Cremation 10		Sykesvil	le, MD
Dallimor	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Figneral Service Licenses, Hard	yler 2	2. Name and Address of Facility 104 S. Main St.		uneral Ho	
	Physician		23a. Part1. Enter the disease, or complications that causes shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition		W	ardin respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) a Due to (or as a co	onsequency of):	CACHCI, II	TIGHTELIC,		
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	death certific	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Live	Fetal death 3	Ectopic pregnancy Other (specify)		Month	Day Year
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cords, r	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but r	ot resulting in the u	nderlying cause given in Part I.	23e. Did tob		e to the cause of death? Probably 4 Unknown
io o o	law requir ias been si e 2 should I	Completed	V Chronic obstryct	ive Pu	Imomy Dis	ease 24a. Was an autops	v prior	autopsy findings available to completion of cause of
	sician: The lav certificate has rector, page 2	Co				perform	ned? death No 1□\	Yes 2□No
N I G	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:		Other	of Death (Check only on		
ō	Physician: r this certific ral director,	-T:	1 ☐ Yes 2 No 1105 Na. 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of	IL 3 DOA 4 INUI	sing Home 5 Reside	ence 6 Other (S ow injury occurred	Specify)
0	ding f h. After funer	tion	1 Natural 5 Pending (Month, Day Y 2 Accident investigation	'ear) Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ N		1-7	
2	Attendii r death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury	- At home, farm, str	eet, factory, office			r Rural Route Number,
5	safte safte al Dire	Certification;	4 Homicide determined building, etc. (эреспу)		City or Town	, 3(4(4)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of response of examiner: On the basis of examiner and manner stated	camination and/or inv				
	To the within To the Comple	Me	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Me	onth, Day, Year)
	7		Shah Her	en, ma	D5160	13	10/6/0	4
	10		30. Name and address of person who completed cause of deat		Print) Fred	en Shah	n) 212	1 2
	Sta	ate	31. Date filed (Month, Day, Year) 32. Begistrar's	Signature	/		- 4/	
4	Registr		BCT Q 8 2004 Sentina	DO A	parks			

Replacement
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004- 3 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Veal **Physician** 2004 FRANK OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORS

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. JOHNS HOPKINS BATVEN MEDICAL CENTER N/A5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months \$☐M 2□F Yrs. Director 575-92-9481 45 Sept. 28,1959 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examinary ust be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 8022 North Boundary Road 21222 23a United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2, ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Laborer Drywall Production other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and Mental h Pages 1 and 2 should be Frank Smith, Sr. Margaret Pisorak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Jeanne O'May / Companion 8022 North Boundary Road Dundalk, MD of Health other altimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: if any injury or once. 5 Other (Specify) ' 4 □ Donation Oak Lawn Cemetery 10/6/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 00 7922 Wise Ave. 16 Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INTRACRANIAL 36 HOUR HEMORRHAGE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner REDUCK HAMMER burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria by Physician/Medical THE HOLD REPROVE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No ed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 22N0 Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir Certification: To Division of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No OCTOSER 1, 2004 UNENGWAIM FELL DON'S STAIR) 2 Accident I Director: d in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 2025 within 24 hours aft To the Funaral Di completely filled in N. BOUNDARY RO AT HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai o the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 2, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

KHAN

W.

31. Date filed (Month, Day, Year)

OCT 15

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MID

4940

32. Registrar's Signature

EAS

MD 21224

BALTIMORE,

AVENUE

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State of Maryland	/ Department of Health	and Mental Hygiene

dap).54		For State Registrar	State of M	aryland /		irtment of		Mental Hy	giene	52 6	Ť,	e ian	0
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	/Medica Examine		4a. Facility Name (If not institution, 5400 LANDING RO	give street and number)			4b. City, Town, ELKR	or Location of De		4c.	County o	f Death		
	Funeral Director		216-23-7968	3. Sex 7. Ag	ge (In yrs. last b 16	rirthday). Yrs.	If Under 1 Year Months Days			rth ay, Year) 8, 19		Count	ace (State or Fo ry) "Land	reign
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	with the	Direc	10e. Street and Number 6407 Michael E.	lizaboth Was	,		10f. Zip Code 2107	16		10g. Citiz	zen of WI	hat Count	ry?	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, it a Madical Experient mail be mailthed at	by Funeral Director	11. Marital Status 17 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.	ŀ	Vas Decedent of	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		14. Race	- America , White, e	tc.	
1215-00	within 72 hounds.	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			(Give life. L	OO NOT use retir	during most of t	vorking			iness/Ind	ustry	
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Baltimore, Maryland 21215-0036	es 1 and of Health f item 27 r other to		19a. Informant's Name/Relationsh Charles & Viviat 20a. Method of Disposition 1 ☎ Burial 2 □ Cremation	Thayer/Pa	20b. Place	640' of Dispo	7 Michae sition (Name of natory or other pl	l Elizab	Date	Hanr 20c. Lo	over,	MD City or Tov	21076 vn, State	_
Baltim	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Meado	Ga Ga	Name and Add	Park 10 Pass of Facility Buffman F	/8/2004 uneral Ho lvd., Elk	ome@i	Meado	owric	Maryland Nge MP,	
1	Physician /Medical Examiner	J.	23a. Part 1. Enter indisease, or shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDue to (or as	d the death. Do	e of):	er the mode of dy	ring, such as card	liac or respiratory a	arrest,			Approximate Interval Betwee Onset and Deal	n th
8760,	ate be thy sicial the bur	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequenc									
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Division of Vital Records,	or Attending ter death. irector: After or by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investig 6 Could n determi	ot be 28e. Place of In	ijury - At home, tc. (Specify)	Time of Injury	W	ork? □Yes 2 X No	28d. Describe Declare Control 28f. Location City or To	Street and	onco	ning v	lost elicl Route Number, ding Do ward C	200
	To the Hospital of within 24 hours af to the Funeral D completely filled in	edical		Physician: To the best xaminer: On the basis of and manner st	of examination a									
	To the within 2 To the complet	W	29b. Signature and title of certifler	And	M		001	nse number Æ	c	29d. Date		(Month, D		
_			30. Name and address of person v	GAN	1			et, Bal	timore, M	aryl.	and 2	21201	L	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	do	als							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9:47 PM John Walter Thomas 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CENTER ROSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 11,1920 Birthplace (State or Foreign Country) 1 M 2□ F Days Hours 215-18-3888 84 Maryland Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Dunda1k Maryland <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 7614 Maple Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 € No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Patapsco College (1-4or 5+) Rail Road Engineer 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Thomas Margaret Schissler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1773 Stokesley Road Dundalk, Maryland Peggy O'Neill Friend 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, ₩ Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 10/7/2004 Dundalk, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify)

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed

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After

Director:

24 hours a e Funeral I

within 2 To the the

death.

Hospital or Attending

Box 68760.

Olvision of Vital Records, P.O.

Pages 1 and 2 should be filed within " nent of Health and Mental Hygiene, ant: If Item 27 Is marked other then ", Lry or other traumatic svent, ILe Max

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

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Physician/Medical ed by the detached þ Completed Be P

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ul Hygiene. : other than "natural", or itema 23a or 28a-f show event. It e Madical Examinar must be notified at Be ပ 20a. Method of Disposition permit. Page Department of Important: If any injury or once. 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death Certification: 5 Pending investigation 1 X Natural 2 Accident 6 Could not be determined 3 🗍 Suicide 4 Homicide

29a. Certifier

29b. Signatu

22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIO-RESPIRATORY Due to (or as a consequence of) SEPSIS Due to (or as a consequence of) CARDIOGENIC SHOCK Due to (or as a consequence of): MYOCARDIAL INFARCTION

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

ARRES

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an

autopsy 2**X** No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Nes

Approximate Interval Between Onset and Death

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. per: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

10/03/200

eted cause of death (Item 23a) (Type, Print) 30. Name a

Medical Exact

certifie

Hospital: 1 X Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

title o

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Mary		partment of I ertificate of		-	giene Reg. No.	ì	0.1.0.01
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 218-59-8257 7. Haves Heal 6. Sex	T/) COUT 7. Age (In	yrs. last birthda 3 Yrs.	y) If Under 1 Year Months Days		8. Date of Bird (Month, Da		Cour	
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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or thems 23s or 28s-f show eumatic event, the May Eal Examinar must be marified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 X Yes 2 No		Hican, etc.)	}	k, White, : Mex:	
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Marvland	d 2 should th and Men 7 is marke treumatic	L C	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Ma	iling Address (Stree	t and Number or Rur		ar, City or Town,	State, Zip	Code)
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Raltimore	Pages nent of I		1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	amoust from State	cemetery, c	rematory or other pla dge Mem. 1		5/2004	Elkrid		
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			23a. Part1. Enter tha isease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the e cause on each line.				or respiratory ar	rest,		Approximate Interval Between Onset and Death
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C O J	The ate h page	Comple	25 W					perfo 1 ☐ Yes	202No 1	eath?	
0 >	Physician: this certific	To Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2 ER/Outpat	ient 3□ DOA Ot	26. Place of Deat ther: 4 \(\subseteq \text{ Nursing Ho} \)		ne) dence 6 □Othe	er (Specif	y)
70 10			27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	254 1011	y A Wo	ıryat ork?]Yes 2.2 No		now injury occurr		cw (
Jel Division	tten deatl stor:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm,	7		28f. Location (S	Street and Number	or or Rura	I Route Number, drag Road
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	To the Hospitel within 24 hours e To the Funerel I completely filled	edical	(Check only one)	ier: On the basis of exa and manner stated.	amination and/or	investigation, in my	opinion, death occur	red at the time,	date and place, a	nd due to	the cause(s)
	To 11	Σ	29b. Signature and title of certifier				se number		29d. Date signed		
	8		30. Name and address of person who co	mpleted cause of death	√\$1€1 ∞ (Item 23a) (Typ	ne, Print)	1853 aton Av		100000	-	12004
			Mc ever Srl	VRMCo, /	MD	900 0	aton Av	2419	Balta	vone	21229
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04-6085 B.K.S

Physicia /Medic		Decedent's Name (First, Middle, I					2. Date of De Month	ath Day	Year	3. Time of Death
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Examine	er	4a. Facility Name (If not institution, g 1105 BALBOA AV			4b. City, Town, or CAPITO	Location of Dea DL HEIGH		4c. County PRINC		RGES
Funeral Director		5. Social Security Number 6 579-06-3022 Usual Residence of Decedent	Sex 7. Age (In 1 ☐ M 2 X F	yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	th ly, Year)), 1951	9. Birthpl Count Ne	lace (State or Fore try) W York
show so at	5	10a. State 10b. County	George's	c. City, Town or Lo	ocation apitol He	ights			10	0d. Inside City Lim
Department of Health and Mental Hygiene. Important: for Items 23a or 28a-f show Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. The Medical Explicational Le notified at once.	by Funeral Director	10e. Street and Number 1105 Balboa			10f. Zip Code	20743		10g. Citizen of		
tems 234	uneral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No rto Rican, etc.)		ce - America ck, White, e	an Indian,
Iral, or l	d by Fu	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 【XNo			Specif		.ack
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:45 P™ Freda M. Workman Oct 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll County General Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs. Director 215-24-3331 95 Nov. 8, 1908 West Virginia Usual Residence of Decedent the Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov or other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iled within 72 hours efter deeth with 5 items 23a 21157 320 Stoner Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 21215-0036 1 ☐ Yes 2 ₹ No Specify: white 3 M Widowed 4 Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Factory Worker Winchester & Woods 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ! 1 and 2 should be ၉ Ezra Workman Mamie Sandy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Depertment of Heelth ar
Importent: If Item 27 Is
any injury or other treu. Mary Bageant - daughter 320 Stoner Avenue, Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 10/6/2004 Elkridge, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, MD 23a. Part1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lute Mu disease or condition resulting in death) TOTAL. 405 /Medical Due to (or as a consequence of): Examiner 40 1 WSON Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Hearing Box 68760, Completed by Physician/Medical 401 Hypoteneron the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
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Division of Vital To the Hospitel

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Medical

4 THomicide

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

OCT 0 8 2004

29a. Certifier

State Registrar 29c. License number

ne me, date and place, and due to the cause(s) and manner as stated.

opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my infowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.

od cause of death

32. Registrar's Signature

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			1 - For State Registrar	State of M	arylar			t of H	ealth a	and M	ental Hy		0 0	n.	310	107
	Physici	an	Decedent's Name (First, Middle, Las								2. Date of De Month	Day	1	Yeer	3. Time of	Death
	/Media		Earle	Maxwell			Walt	er			Octobe	er 4,	200		9:24	A M
	Examir	er	4a. Facility Name (If not institution, give		L . 1		_		Location of	of Death				of Death		
			Washington Advent				Tako							omery	7	
	Funeral Director		5. Social Security Number 229–09–4296 11 Usual Residence of Decedent	ox 7. Ag ⊠M 2□ F	83	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 2	th 12 Year)	21	9. Birth Cour Lind	olace (State of etry) en, V	or Foreign A
	and and		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							1	0d. Inside Ci	ity Limits
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	eath	era	11. Marital Status	12. Was Decedent	Ever in I	15 13 1			enanic Ori	nin2 (Spec	cify Yes or No			. Amada	an Indian,	
	ter d	Ę	1 ☐ Never Married 2 ☐ Married	Amed Forces?	10		f Yes, spec	fy Cuba	n, Mexican	, Puerto F	Rican, etc.)	,-		k, White,		
99	urs al		3 ∰ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		45	1 ☐ Yes 2	2 <mark>∳</mark> No	Specify:			i	Specify.	Whi	te	
ŏ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The International High and Page any injury or other traumatic event. The Medical Evantral must be notified at annex.	Be Completed by	15. Decedent's Ed			16a. Deced	dent's Usua	l Occupa	ition			16b. Ki	nd of Bu	siness/Inc	lustry	
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Baltimore, Maryland 21215-0036	shound M mar	-	19a. Informant's Name/Relationship (7	vpe, Print)		19b. Mailin	a Address	(Street a	nd Numbe	r or Rumi	Route Numbe	er City o			Code)	
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ā,	Heartern other		20a. Method of Disposition	Daughter	20b. I	Place of Dispo	sition (Nam	e of	1		ate MID			City or To	wn. State	
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Division of Vital Records,	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	ation; To	1 Yes 2 ZXNo 27. Manner of Death 1 ZNatural 5 Pending 2 Accident investigation	1 🖾 Inpatie 28a. Date of Injur (Month, Day		28b. Time of Injury		lc. Injury Work	4 🗆 1401	28	e 5 Resid)	
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	0,	-	30. Name and address of person who	ompleted cause of de	eath (Iten	n 23a) (Tvpe. F	Print)									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 20a b.c per fib 8836 10-28-04 Health and Mental Hygiene 1 - For State Registra Certificate of Death 100 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21, **Physician** Jane Webster September 2004 11:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/08/1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Director 225-09-8111 West Virginia 90 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 23a or 28e-f show 10d. Inside City Limits 1 ☐ Yes 2 X No MD Montgomery Kensington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 Colchester Drive 20895 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any lighty or other treumatic event once. 17. Father's Name (First, Middle, Last 18, Mother's Name (First, Middle, Maiden Sumame) Charles Aby Rhodes Clara Crouch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug Coggins, Personal Rep. 8905 Fairview Rd, Ste. 600, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 11-3-04 Rockville Md. Parking and the state of the st 1 X Burial 2 X Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Distress /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Error briderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Aspiration Pneumonia and Due to (or as a consequence of) physician a O. Box 68760. Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ End Stage Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Chronic Anemia 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: ۵ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei C 29a. Certifier Medical 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0060036 10/05/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmoud Doski, MD 1299 Lamberton Drive, Silver Spring, Maryland 20902

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 8 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician 6:50 A M October 0 Andrew Howard White 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westernport Allegany Moran Manor Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Jan. 26,1914 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 11XM 2□ F Months Days Hours Min. 90 146-05-7246 Jan. Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Director WV Pendleton Upper Tract 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ž E ò HC 32. Box 62-B 26866 or Itams 23e USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or lan any injury or other traumetic event, the Medical Examines 2008. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Artesian Well Driller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Neal White Elizabeth Finn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty M. Dickson HC 32, Box 62-B Upper Tract, WV 26866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fernwood Cemetery 10-07-04 Jamesburg, N.J. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home PA 7- Wayne X50a 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** my o cordid /Medical Due to (or as a consequence of) **Examiner** orm m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day signed by the a 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Tes 2 No 3 ☐ Probably ↓ Unknown peeu : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? ara 2 No 1 ☐ Yes or Attending Physicien: director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: ٩ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury a Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg Plaza, Frostburg, Maryland Dr. Jesus Tan 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DCT 0 8 2004** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Year 1:27 PM SEPTEMBER James Robert Yerkes 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rising Sun

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year FEB 12, 19) Calvert Manor Healthcare Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Months 1X M 2□ F 85 Director 215-16-6864 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Worke** ir than "natural", or itams 23a or 28a-f ehov The Wedical Expedience must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1168 Calvert Road 21911 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? WOTIG 1 Ness 2 No War II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural; or item any Injury or other traumatic event, the Medical Exercit Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No δ Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) District Manager Candy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willett C. Yerkes ပ Myra Kimball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Bruce Yerkes/Son 103 Green Meadow Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 4, 1 Burial 2 □ Cremation 3 □ Removal from State Rose Bank Cemetery 2004 4 ☐ Donation 5 ☐ Other (Specify) Calvert, Maryland 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 ed CM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition RESPIRATIONY **Physician** FAILUNE resulting in death) /Medical Due to (or as a consequence of): Examiner HNONIC OBSTRCTIVE PULMOTHERY DISTASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physiclan/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ACHALASIA 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown HRITERY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? certificate of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 452 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No ို 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 🗌 Yes 2 No after death | Director: / d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Cheek of one) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H28410 SEPTEMBER 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

1881 TELECULARA ROAD, KISING SUN MD 2191

DONHAM, D.O.

OCT 0 8 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 21,2004 **Physician** E. Lavada Au 12:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Yrs. 405-22-4349 81 Director 3, June 1923 Kentucky Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Itam 27 Is marked other than "netural", or Itema 23s or 28s-1 ehow any injury operiter treumatic event, Its Marical Examiner ciust be notified at once. 1 ☐Yes 2X No Directo Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10908 Bolton Drive 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Hopkins Laura Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred A. Au/Husband 10908 Bolton Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of September 27, 20c. Location - City or Town, State completely, crematory or other place Parklawn Memorial Park 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) 2004 Rockville, Maryland Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspira Physician day /Medical Due to (or as | consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury signed by the attending physicien and I be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No 1 Tes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica 25. Was case referred to medical examiner?
1 □ Yes 2√No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ī npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLUD Stulo 330 Rockull MEMPHIRATIA 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 4 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2AM^M Michael Anderson Sept. 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2719 Overdale Place Forestville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 4/5/1971 6. Sax 9. Birthplace (State or Foreign **Funeral №** M 2 F Director 33 Wash. D.C. 578-92-6650 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 ehow unt be notified at XXYes 2□No Director P.G. Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 U.S.A. 2719 Overdale Place or Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status the Medical Extendrine I Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: Black If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) , Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Private marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked oth Be Arthur Anderson Cornelia Dendy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrina Anderson/wife 2719 Overdale Pl. Forestville, MD. 20747 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Importent: If itee ₩ Burial 2 Cremation 3 Removal from State Resurrection Cem. 10/2/04 Clinton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service License 3910 Silver Hill RD.Suitland, MD.20746 Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications of Gardner's Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit certificate be executed and Due to (or as a consequence of) as the burialthe attending physicien Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No detached 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificete Division of Vital 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pendina death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MD004588

DHMH 17 Rev 1/2001

?

Registrar

State

Maryland 21215-0036

Baltimore.

Box 68760.

P.O. 1

Mercantile

Way landog md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221

32. Registrar's Signature

Johnson MJ

31. Date filed (Month, Day, Year)

OCT 0 8 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** John Edwin Board September 21, 2004 2:15 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 X M 2 □ F Yrs. Director 80 1923 136-40-2566 England Usual Residence of Decedent the Maryland perruit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampliury or other traumatic event, the Medical Event item rate is notified at any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1K Yes 2 No Florida Lee Ft. Myers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 2 15157 Oxford Cove, 33919 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 John Edwin Board Elizabeth Matthew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Board/Wife 15157 Oxford Cove, #2, Ft. Myers, Florida 33919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 9/25/2004 Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Lig 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock 2 days /Medical Due to (or as a consequence of): **Examiner** _{b.} Sepsis Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last uays Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Urinary Tract Infection Due to (or as a consequence of): Box 68760. d Aspiration Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Dementia, Parkinsons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2X No Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006168 September 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Kirkcaldy, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 24 2004 Darker Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Yeer **Physician** М Louis Benjamin September 20 2004 2006 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 2□ F Hours Months Days Director 578-07-2527 94 12, 1910 North Carolina Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County rthen "natural", or items 23a or 28e-f show the Medical Experience that be notified at 1 TYes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 N. H. Burroughs Ave., N.E. 20019 United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after Hygiene. 1 Yes 27 No ff Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be finent of Health and Mental Is not: If item 27 is marked of Eliza Benjamin John Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Ratiff - Daughter 1209 Booneshill Rd., #1, Capitol Hgts., MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State rtment of 1 Burial 2 Cremation 3 Removal from State = 5 Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 9/30/2004 Olivet Cemetery Wash., DC Mt. permit. Departn 22. Name and Address of Facility 21. Signature of Fureral Service Licensee Stewarts Funeral Home 23a. Pert1. Ever the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line.

Immediate C use (Finaf disease or condition resulting in death)

a MACANAM ARRANDA 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Hinknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1□ Yes 20 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 [Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 3 DOA 2 ER/Outpatient After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8416 Central Ave., Landover, MD Ophnell Cumberbatch, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State 2 7 2004 Registrar SEP

		For State Registrar	State o	f Marylan	_	artment of H			giene Reg. No.	04 31915
Physicia	in	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year 3. Time of Death
/Medica Examine		Laura L. Brown 4a. Facility Name (If not institution, given	re street and nur	mber)		4b. City, Town, or	Location of Dea			18, 2004 11:25A Dunty of Death
Funeral		·	ng and] Sex 1□M 2X)F	7. Age (In yrs.	last birthday) Yrs.	Burtons If Under 1 Year Months Days	ville If Under 24 Hr Hours Mir		th	9. Birthplace (State or Foreign Country)
Director		227-16-9832 Usual Residence of Decedent 10a, State 10b, County		80	ty, Town or Lo			Dec 5,	1923	Virginia
e Maryla Ba-f ehov	ctor	Maryland Montgo	mery		rtonsv					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23a or 2	Funeral Director	10e. Street and Number 3808 Lansdale Ct				10f. Zip Code 20866			10g. Citizer	n of What Country?
3 S	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		24E]No ∕e		Was Decedent of His f Yes, specify Cubar	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14.	Race - American Indian, Black, White, etc. pecify: Black
thin 72 ho de. den "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) Callege (1	I-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	urina most of w	orking	16b. Kind	of Business/Industry
FICE A I	Be	12 17. Father's Name (First, Middle, Las	י		Sup	ervisor	18. Mother's Na	ame (First, Middle,		L Housekeeping
2 should and Meni sand Meni sand Meni sand markersangers	ှ	Samuel Oliver 19a. Informant's Name/Relationship	(Турө, Print)		19b. Mailir	ng Address (Street a		Tucker Rural Route Numbe	er, City or To	iown, State, Zip Code)
Pages 1 and tent of Health tent: if item 27 jury or other tr		Anita A. Brown/D 20a. Method of Disposition 1 🖁 Burial 2 □ Cremation 3 [Removal from	State	Place of Dispo cemetery, crer	Lansdale sition (Name of natory or other place	9)	Date	20c. Locat	tion - City or Town, State
Deartil. P. Departme important any injury once.		. 4 □Donation 5 □Other (Special Service Lice 1) 1. Signature of Funeral Service Lice 1.		Hay	22	2. Name and Addres	s of Facility Hi:	nes-Rina	ldi Fu	Landover , MD meral Home Spring, MD 20904
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aAcut		cytic					Approximate Interval Between Onset and Death
cate be executed physician and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq (or as a conseq						
D := □ ii	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1□Live b	icome of pregna birth 2 Feta nant at time of d own	Il death 3	Ectopic pregnancy Other (specify)			23d	d. Date of delivery Month Day Year
w requires that seem signed by should be detailed	ρλ	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause give	n in Part I.			contribute to the cause of death?
	Completed							24a. Was autor perfo 1 \(\subseteq Yes	osy ermed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
SION OF VICAL IN tending Physician: The leath. tor: After this certificate to the funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien		r. 4🛚 Nursing	Home 5 Residuel	one) dence 6	
	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not a determined	on (Moni	th, Day Year)	Injury ome, farm, str y)	28c. Injury Work M 1 7	? ′es 2 □ No		Street and N	Jumber or Rural Route Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the b	best of my kno asis of examina ner stated.	owledge, death	n occurred at the tim vestigation, in my op	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as stated. ace, and due to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	Ser			29c. License B55788				igned (Month, Day, Year) mber 22, 2004
7		30. Name and address of person who Dorothy Say, M.					te #205	Silver	Sprin	g, MD 20901
Stat Registra		31. Date filed (Month, Day, Year) SEP 2 4		egistrar's Signa		Spark	2			

	Carl 04-06 RPD		For Amend Item 20	Type or Print in State of Maryla b-c&Unpend I				legial Hyo	iene 21-04 t		
	Physici	an	1. Decedent's Name (First, Middle, Las	()		incate of	Deam	2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medi Examir	al	CARL 4a. Facility Name (If not institution, give	BATTLE street and number)		4b. City, Town, o	or Location of Death	Octobe	er 1, 20		0845 P M
	= 74411111		Holy Cross Hospit	al		Silver 9	_		Monto	jomer	У
9	Funeral Director		220-11-9888	7. Age (In yr 32	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 7,	Year) 1972		place (State or Foreign ntry) D.C.
7	/land		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				1	Od. Inside City Limits
	tiled within 72 hours atter death with the Maryland Hygiene. tther than "natural", or Items 23a or 28e-f show tther the Medical Examinar rust be notified at	ctor	MD. Montgome	ery	Silver	Spring					XXYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	Nhat Cour	ntry?
	s 23a		1907 Locust Grove		110	20910			U.S.A.		
10	tter de	Funeral	11. Marital Status N☐ Never Married 2☐ Married	12. Was Decedent Ever in Armed Forces? 1 Tyes 27 No	10.5.	Was Decedent of the If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	etc.
Maryland 21215-0036	"natural", or		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 25 ☐ No If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Specif	Bla	ck
5-0	s 1 and 2 should ba tiled within 72 hc I Health and Mental Hygiene. Item 27 is marked other than "natun other traumatic event, the Mcdical	Completed by	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of work	ing	16b. Kind of B	usiness/In	dustry
121	within ane. than	ldmi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	,		-		
d 2	filed Hygi other	a	12th 17. Father's Name (First, Middle, Last)		waren	ouse Spe	18. Mother's Name	(First, Middle,	Privat Maiden Suman		
<u>lan</u>	2 should be titled within and Mental Hygiene. Is marked other than aumatic event, the Ma	To B	Matthew Battle				Annie F	Ruth Mer	cer		
lary	and h	-	19a. Informant's Name/Relationship (7				and Number or Rura		_		
	and lealth m 27 her tr		Matthew Battle/Fat				Grove Rd.,	-			-
Jore	iges 1 nt of H : If Ite or of		20a. Method of Disposition 1	nemovarmom state		sition (Name of matory or other pla		Date	20c. Location		own, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trai once.		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			hurch Cei 2. Name and Addre	netery 10-				
Ba	permit. Depart Import any inj) Behal	Lengton			ly St., N.	hnson & W. Wash			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de						2001	Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Head injur Due to (or as a cons	ies						Onset and Death
	<u> </u>	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):					_	
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	e executed ian and urial-transit	Exa	resulting in death) Last	Due to (or as a cons	sequence of):						
9289	ate be nysicia he bu	Ical	(d							
39 x	artitica Jing pl	Med	IF FEMALE:	220 If you system of pro-							
P.O. Box	the death cartilicate be y the attending physicia ched tor use as the bur	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delive onth	ery Day Year
Vital Records, P.	Physiclan: The law requires that the death this certificate has been signed by the atternal director, page 2 should be detached for	by	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to			he cause of death?
CO	w requir	ompleted						24a. Was a		Were auto	ppsy findings available
Re	The lav	mo						autop: perfor	med? 2 No	death?	mpletion of cause of 2□ No
ital	ysiclan: Th is certiticate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			200	
) \	Physic this ce al dire	70	1 ZYes 2 □ No		EP/Outpatier	IL SEL DOA	ner: 4 - Nursing Ho				(y)
on o	ding Ph h. After th tuneral	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year		Wo	rk?	28d. Describe h		red	
Division of	oatl or:	ertification;	Accident investigation Suicide 6 Could not be determined	28e. Place of Injury - A	Unknow t home, farm, str		Yes 2X No	Subject 28f. Location (S	Street and Numl	er or Run	al Route Number,
Div	lospitel or Attu t hours after de cuneral Directo ely tilled in by ti	O	4 Homicide	Unknown	ecify)			City or Tow lontgome	n, State) ry Cour	ity, l	MD
	Hoss 24 hol Fune etely th	dical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my aniner: On the basis of exame and manner stated.	knowledge, deat lination and/or in	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the or red at the time, o	cause(s) and maded date and place,	and due to	tated. o the cause(s)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

S. P. HOGAL 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

OCT 0 5 2004 Person who complete cause of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 2, 2004

Amend Trem 18 per fin G838 12-28-04 tas. Ensure All Copies Are Legible. 1- For Unpend Item 23ac 27 of Maryland Department of Health and Mental Hygiene Jerry Barnes -6298KG 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician September 30, 2004 7:30 P JERRY L. BARNES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's County Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** XXM 2□F Yrs. WASHINGTON, DC 13, 1977 Director 218 41 3707 Usual Residence of Decedent 10d. Inside City Limits Manyland 10c. City, Town or Location 10b. County 10a. State ral', or Itama 23a or 28a-f show Examiner must be notified at XX Yes 2 No Director PRINCE GEROGES CAPITOL HEIGHTS MARYLAND the 10g. Citizen of What Country? 10e. Street and Number 20743 UNITED STATES 310 ZELMA AVENUE death Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status be filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: XX Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: BLACK Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 'natural' d other than "nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL (SAFEWAY) 12TH SALES CLERK Ith and Mental Hygis 27 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be TOLATHA ROSS Tolotha Roane T. JERRY BARNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAPITOL HEIGHTS, MD 20743 310 ZELMA AVENUE Health Item 27 T. JERRY BARNES FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If Ite any Injury or ot once. tXBurial 2 ☐ Cremation 3 ☐ Removal from State SALEM CHURCH CEMETERY 10/09/2004 MONTROSS, VA * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD / FISHER F.H. MARSHALL'S FUNERAL HOME OF 1 4308 SUITLAND ROAD SUITLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SUITLAND, MD 20746 Approximate Interval Between Onset and Death Cardiac Arrythmia Due To Hypertrophic Cardiomyopathy mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, flam, loading to kins solate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No certificate Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🗌 Nursing Home 2 Proutpatient 3 DOA 5 Residence 6 Other (Specify) Certification; To 1 XYes 2 No this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat uneral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 Homicide 24 hours e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 October 1, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 5 2004

Registrar's Signature

m)

Pamela E. Southall,

111 Penn Street, Baltimore, Maryland 21201

04 - 6029B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ERIC T. BUCKINGHAM State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** BUCKINGHAM SEPT 19, 2004 0430 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner I-83 NORTH BOUND SCALE HOUSE BALTIMORE MONKTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□F Months 199 64 2101 26 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at WP 1 ☐ Yes 2 No Director W. MANCHESTER ORK 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 17404 EHRS Itema 23a U.S.A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MANUFACTURING al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 RECIEVING PERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be shoutd be and Mentail Buckingham 2 10MMY JAUGH ERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cay or itam 27 BUCKINGHAM /MOTHER 325 BUTTER DAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages SEPT. 23 2009 ō 1 Burial 2 Cremation 3 Removal from State ö Department of Important: If any Injury or once. CARDENS 4 ☐ Donation 5 ☐ Other (Specify) TORK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. KEFFER EUNERAL HOME YOHN At 17403 902 MT. ROSE AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WILS Multiple /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medicai Examiner the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy ঠ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No page 2 s 1 Yes Division of Vital 2 🗆 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ XXYes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🖔 Other (Specify) AT SCENE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred occupant of a Certification: the Hospital or Attanding 1 Natural
2 Accident
3 Suicide Found 3:17 car that hit fixed object 5 Pending 19/04 1 ☐ Yes 2 No death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HIGHWAY 281. Location (Street and Number or Rural Route Number, City or Town, State) I-83 North at Scale House Mankton HD in by 4 Homicide filled 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 O.C.M.E 19, 2004 SEPT. allanma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AU w 111 Penn Street, Baltimore, Maryland 21201 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCT 0 8 2004

	State of Maryland / Department of H Certificate of L	The state of the s
Olympiais	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
Physician /Medical	John Durburrow Blair III	September 16, 2004 11:17 AM
Examiner	4a Facility Name (If not institution, give street and number) Prince George's Hospital Center	b. City, Town, or Location of Death Cheverly 4c. County of Death Prince George's
Funeral Director	5. Social Security Number 229-20-7830 6. Sex 17 M 2 F 80 Yrs. 18st birthday Months Days	If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia
p s	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryla a-f sho ffled at		1 Yes 2 No
vith the Mar or 28a-f sl be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
23a vi	203 Matoaka Road 23226	5 USA
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exterdinar mast be notified at	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1942 1 ☐ Yes 2 ☑ No Year or Dates: 10/6	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) Specify: 14. Race - American Indian, Black, White, etc. Specify: White
5-0 72 ho 72 ho	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired,	ation 16b. Kind of Business/Industry
1 21215-00 ed within 72 hou ygiene. Ser than "natura it, the Medical Ent.	Elementary/Secondary (0-12) College (1-4or 5+) President	
d 2121 filed within Hygiene. ther than " int, the Me	17. Father's Name (First, Middle, Last)	Blair Transit Co. 18. Mother's Name (First, Middle, Maiden Sumame)
yland yland build be fil Mental H arked out artic even	John D. Blair, Jr.	Genevieve Lathrop
Marylated 2 should be the and Menta 7 is marked traumatic et traumatic To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	and Number or Rural Route Number, City or Town, State, Zip Code)
	Mary Shepherd Blair - Wife 203 Matoaka	
Baltimore, I semit. Pages 1 and Deportment of Healt moortant: if item 2 any injury or other ance.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place the Notleywood Cemeter)	
Baltimol permit. Pages Depertment of important: If it any injury or c		
Balt permit. Depertrimports imports any inju		s of Facility Lt Funeral Home Cutshaw Ave. Richmond, VA
	23a, Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Onset and Death
by Saminer	Sequentially list conditions. Due to (or as a consequence of):	Marchean
O, s exect an en an en intel-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):	2 Desert
r 68760, rutificate be executed ng physician an as the buriel-tr-nsit	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a covisequence of):	
Box 6i eath certific attending p for use as	d	
P.O. Box lat the death cert dby the attendin leteched for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	on in Part I. 23b. Did tobacco use contribute to the cause of death?
		1 Ges 2 No 3 Probably
cords, w requires the bean signer should be collected by		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
al Record The law requir ate has been s page 2 should		completion of cause of death?
The I		1 L Yes 2 X No 1 □ Yes 2 □ No
of Vital Physician: Trhis certificat ral director, po	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
Of Physic this cral direction : To	1 ☐ Yes 2 No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othe 27. Manper of Leath 28a. Date of Injury 28b. Time of 28c. Injury	4 Li Nuising nome 5 Li Residence 6 Li Other (Specify)
ding ding the After fune	1 Delatural 5 Pending (Month, Day Year) Injury Work	res 2 \sum No
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours effer death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospital or 24 hours effe 24 hours effe 54 hours effe Funeral Dir stely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time	e, date and place, and due to the cause(s) and manner as stated.
he Hospi in 24 hou he Funer pletely fii edical	(Check only one) Acidical Examiner: On the basis of examination and/or investigation, in my op and manner stated.	inion, death occurred at the time, date and place, and due to the cause(s)
To the company of the	29b. Signature and title of certifier 29c. License	number 29d. Date signed (Month, Pay, Year)
	1/ /slavi 03	103/8 9/16/0x
0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001	Hospital Drive
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	erly, Maryland 20785
State Registrar		
DHMH 16 Rev 6/95	OCT 0 8 2004 Server & Sporter	<u> </u>

RI	PD			end Item		larylar Sarylar	nd / Depa per me <i>Ce</i>	artmei rtifica	ot of Heate of De	alth and eath	Mental H	ygier Reg. N	2004	31921		
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of I Month		Day Year			
	/Media	al	September 29,													
	Examir	er	4a. Facility Name (If not institution, give street and number) Suburban Hospital						thesda	cation of Dea	ın	4c. County of Death Montgomery				
2	Funeral		5. Social Security Nur 127-40-09		x 7. A	ge (In yrs,	ast birthday)		r 1 Year If	Under 24 Hrs		Birth	9 Bir	thplace (State or Foreign		
3	Director		127-40-09	01 10]M 2∰F	5.5	Yrs.	Months	Days	Hours Min	Feb. 1	3°, Yei	1951 Buf9	Taro, NY		
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	laryla shor	5	MD. Montgomery Chevy Chase								10d. Inside City Limits 12 Yes 2 □ No					
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36	h with	io le	6307 Broa	dbranch	Rd			208					JSA	James J.		
	be filed within 72 hours efter deeth with the Maryland tal Hyglene. of other then "natural", or Iteme 23a or 28e-f show event, the Medical Examinar must be inclined at	by Funeral Director	11. Marital Status t Never Marrie 3 Widowed 4		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖰 No If Yes, Give Year or Dates:		i	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:			No-	erican Indian, re, etc.				
Õ	2 hou	ed		15. Decedent's Educ			cation 16a. Dece		ual Occupatio	n		Specify: White 16b. Kind of Business/Industry				
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2	ad wit	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		5+		Psycho	other	apist			He	ealth			
pu	m - 0 5		17. Father's Name (F								me (First, Midd	le, Maide	en Sumame)			
<u></u>	12 should be filed within h and Mental Hygiene. 7 Is marked other then " recumatic event, the Mer	10		ozen			Т				usher					
Sa	d 2 st th and t7 Is n treun		19a. Informant's Nar George D.										or Town, State, .			
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be Depertment of Health and Menta Importent: If Item 27 is marked any Injury 9 other freumatic events.		20a. Method of Dispo			1	Place of Dispo cemetery, crer				Date	20c.	Location - City or	Town, State		
Ē				Cremation 3 II		9	k Hill			10/4	/2004	Was	shington	D.C.		
Salt			21. Signature of Fun	eral Service Licens	99							wle	r's Sons			
-			Due	195	X						I.W., WI		20016			
	Physician /Medical		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	tailure. List only o inal	ne cause on each	ple d	rug in			such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death		
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	cuted Ind ransit	Examiner	Sequentially list condit any, leading to immoduse. Enter Underlicause (Disease or in that initiated events	_	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d											
68760,	icate be executed physicien and s the burial-transit	edical Ex	resulting in death) La	ast												
Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 m 1 ☐ Yes 2 2 9 ☐ Unknown	pregnant	3c. If yes, outcom 1 ∐Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Feta	al death 3	Ectopic p					23d. Date of del Month	ivery Day Year		
P.O.	that the polytra that t	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of							use contribute to	contribute to the cause of death?					
of Vital Records,	w requires been sign should be	ed b									1] Yes	No 3 Probably 4 □Unknown			
000	law relas bee	Completed								24a. W						
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Ľ.	ding F	lol	27. Manner of Death 1 ☐ Natural	5 Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		Work?			e how injury occurred				
Division	Attending Physicien: r death. sector: After this certifice by the funeral director, r	Icat	2 ☐ Accident 3 v Suicide	investigation 6 Could not be	9-29-0		Unkno			2 X No		Subject ingested drugs				
Diς	after after Direct	ertii	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num. City or Town, State) 6 Chevy Chase. M							(e) 6307 B	roadbranch D					
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification;	29a. Certifier (Check only one)	Certifying Phy	sician: To the bes	ian: To the best of my knowledge, death occurred at the time, of the basis of examination and/or investigation, in my opinion and manner stated.			The vy Chas me, date and place, and due to the cause opinion, death occurred at the time, date a			u(e) and manner as stated				
	within 2 To the comple	Me	29b. Signature and ti	ne of certifies	~			29c. License number 29				29d. D	9d. Date signed (Month, Day, Year)			
			XIIL	when	Wi)			0	.C.M.E	G.,		September 30, 2004				
		4	30 Name and address	ss of person who co	ompleted cause of	death (Iter	n 23a) (Type,		Penn S	street,	Baltim		Marylar			
	Sta		31. Date filed (Month			trar's Signa	ature 4	An	aks				· · · · · · · · · · · · · · · · · · ·			
	Registi	ar	110	T 05 200	4 /2		~	Jugar	- Barrier State							

04 - 6057B.K.S UNKNOWN 04-309

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joshua L. Carten For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Joshua L. Carter SEPT 20, 2004 0645 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6900 CENTRAL AVENUE CAPITOL HEIGHTS PRINCE GEORGES 8. Date of Birth (Month, Day, Y Mar. 22, If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Hours 273-92-6877 14 Ĩ990 Director Ohio Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location **ehow** 10d. Inside City Limits in then "naturel", or items 23e or 28e-f ehov the Medical Examinar must be notified at 1 XYes 2 No DC Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5311 E St., S.E. #105 20019 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. African permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or iter eny injury or other treumatic event, the Medical Expanding 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Student None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otis Hatcher Ernestine Carter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5311 E St., S.E. #105, Wash., DC <u> Otis Hatcher - Father</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 9/28/2004 ^¹ 4 □ Donation 5 □ Other (Specify) Wash., DC 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease or condition resulting in death) **Physician** tiple aunshot /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit the death certificate be executed Due to (or as a consequence of): Records. P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Pop in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed has 1X Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ${}_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6XXQ ther (Specify) AT SCENE 2 1

Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Fourth 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation 1 Natural *Subject* 9-20-04 Shot 06:45M death. 1 ☐ Yes 2 📈 No 2 Accident Director: Suicide 6 ☐ Could not be Julicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ity of Toll T. State) determined 0 outside 24 hours a Heights 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Dav. Year) O.C.M.E SEPT. 21, 2004 40

Registrar DHMH 17 Rev 1/2001

State

ame and address of person who completed cause

SEP 2 7 2004

31. Date filed (Month, Day, Year)

eath (Item 23a) (Type, Print)

Registrar's Signature

POLICE Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day SEPTEMBER 22, **Physician** 2004 OROTHY ORWIN 1:08A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City Town or Location of Death **Examiner** MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 24, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1□ M 2⋤ F NEW YORK Yrs. 91 057-07-0113 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count 28a-f show other traumatic event, the Medical Examiner, just be notified at 1 Aves 2 No Director MARYLAND MONTGOMERY CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 #1704 20815 UNITED STATES OF AMERICA 8100 CONNECTICUT AVE. Items 23a Be Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: f Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced WHITE "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MUSEUM GUIDE MUSEUM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of GOLDIE "UNKNOWN" ISADORE SACHS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD CORWIN - HUSBAND 8100 CONNECTICUT AVE #1704, CHEVY CHASE, MD 20815 Health i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 Kemoval from State Department of Important: If any injury or once. MT. ARARAT CEMETERY 09/26/04 FARMINGDALE, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL LUFARCTION Physician disease or condition resulting in death) /Medical Examiner ORONARY ARTERY 20 Y CS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by HYPERTEN SION)IABETES 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 No i Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed ARTLW S. KAN CVSKY Chery chare ed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave #730 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 24 2004 Registrar

			1 - For State Registrar	te of Maryland		artment of F			giene) [31924
	- · ·		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of Death
	Physicia /Medic		Harry V. Channell, J	r.				Septemb		2004	12:45 AM
	Examin	er	4a. Facility Name (If not institution, give street a.	nd number)		4b. City, Town, o Walker		eath	4c. County	of Death deric	1.
			Galde Valley Nursing 5. Social Security Number 6. Sex	Home 7. Age (In yrs. Ia	ast hirthday)	If Under 1 Year		Irs. 8. Date of Birtl	h		ace (State or Foreign
	Funeral Director		216-20-2352 1\mathred{X} ^M 2E		Yrs.	Months Days	Hours M	June 5,	1925	Coun	Land
	P		Usual Residence of Decedent	10- 6-	T						
	show	7	10a. State 10b. County		, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2 X No
	28e-f	Directo	Maryland Frederick 10e. Street and Number	ıj	amsvil	10f. Zip Code			10g. Citizen of	What Coun	
	3a or		2728 Hillside Court			21754			United		-
	death	Funeral	11. Marital Status 12. Wa.	s Decedent Ever in U.S	S. 13. \	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	ce - Americ	
92	or Ite	y Fu	1 Never Married 2 Married 1 If You	Yes 2. ŽŠNo es, Give		Yes 2⊠ No	Specify:	one moun, etc.,		_{y:} Whit	
8	filed within 72 hours after death with the Maryland Hygiene. utter then "naturel", or Hems 23a or 28e-f show shi, the Medical Evant withing the moffled at	Completed by	3 ☐ Widowed 4 ☐ Wivorced Yes	r or Dates:	16a. Deced	fent's Usual Occup	pation		16b. Kind of B	usiness/Inc	fustry
75	nin 72 In "na Medis	piet	(Specify only highest grade comp	leted) lege (1-4or 5+)	(Give life. l	kind of work done OO NOT use retired	during most of (d)	working			•
2	filed with Hygiene ither the	Com	12			Steel Wor				el Mil	_1
Baltimore, Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last) Harry V. Channell					Name <i>(First, Middl</i> e, La Backman		ne)	
<u> </u>	2 should be and Mental Is marked crsumatic ever	은	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailir	g Address (Street	and Number or	Rural Route Numbe	r, City or Town,	State, Zip	Code)
<u>≅</u>	nd 2 salth ar 27 is r trsu		Michael Channell / So		2728	Hillside	Court	Ijamsvill	e, MD 2	21754	·
J.e	permit. Pages 1 and 2 Department of Health s Important: If item 27 It any injury or other trs		20a. Method of Disposition 1 □ Burial 24 Cremation 3 □ Remova		ace of Dispo	sition (Name of natory or other place		Date	20c. Location	- City or To	wn, State
Ē	Page ment of ant: If ury or		* 4 □ Donation 5 □ Other (Specify)		reder	ick Crema	itory	25-04	Freder	ick,	MD
3alt	Separt nport ny inj		21. Signature Fineral Service Licensee	00				Stauffer F			
	00780		230 Part Enter the disease or complications	Wallansed the death				Pike Fred		MD 21	.702 Approximate
	Diam't day		23a. Part1 Enter the dispase, or complications shock, or heart failure. List only one caus Immediate Cause (Final	e on pact line.			.9, 00000	nao or roopitatory at			Interval Between Inset and Death
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	p ii	Iner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a cons∋qu	ence of):						
	and and I-trans	Examiner	that initiated events	ue to (or as a consequ	ence of):						
8760,	icate be executed physician and s the burial-transit	dlcal E									
687	ifficate g physas the	ledlo	U								
Вох	death certifica attending pt d for use as t	an/M	23b. was decedent pregnant	es, outcome of pregnat		Ectopic pregnancy	,			te of delive	*
О. В	The taw requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	Pregnant at time of de Unknown		Other (specify)	<u>. </u>		MC	onth	Day Year
مز	that the		Part II. Other significant conditions contributing	g to death but not resu	il yi ng in the u	ndertying cause gry	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
ds,	uires tha signed Id be del	d by	Rente Myora	ideal of	refor	ction		1 🗆 Y	es 22 No	3 🗆 Proba	ably 4 Unknown
COL	w requir s been si should	olete	Desnestra	/	0			24a. Was		Were autop	osy findings available
Be	The tay	Completed						 autop perfor 1 ☐ Yes 	med2	prior to con death? 1 Yes	npletion of cause of 2 No
Vital Record		Be C	25. Was case referred to medical examiner?				26. Place of E	Death (Check only or			
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uo.	ding F h. After funeri	tlon;	1 ZNatural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2. No	28d. Describe h	low injury occur	IAG	
Division of	or Attending Physicien: after death. Director: After this certification by the funeral director.	ertiflcation;	2 □ Could not be	Place of Injury - At ho building, etc. (Specify	me, farm, str			28f. Location (S	treet and Numb	er or Rura	Route Number,
ă	s after s after of Dire	Certi	4 Homicide	building, etc. (Specify)			City or Tow	m, State)		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier Certifying Physician: (Check only 2 Medical Examiner: Or	the basis of examinat	wledge, death ion and/or in	occurred at the tir	me, date and pla ppinion, death o	ace, and due to the o	cause(s) and made and place,	anner as stand due to	ated. the cause(s)
	To the h within 24 To the F complete	Medi		d manner stated.		29c. Licens		· · · · · · · · · · · · · · · · · · ·	29d. Date signe		
	¥ 5 8) Au A			D7	6. SIL	,	Com	72	7004
	_	1	and a dress of person who complete	d cause of death (Item	23a) (Type,	Print) A	10-0		2771	1.	, , ,
_	5		MIEN J' Gilson mo	1475 T	ANEY	/N<	rued	M	2190	2	
	Sta		31 Date filed (Month, Day, Year)	32. Registrar's Signat	ure						
	Regist	al	SEP 2 4 2004	Deneva		1000	Kal				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of M	faryland / D	epartme Certifica					Reg. No.	2004	31925		
Physi /Med Exam	lical	Decedent's Name (First, Middle Land Land Land Land Land Land Land Land	n, give street and number	2-mm		y, Town, or			2. Date of De Month	Day 2 4c. Co	Year 2007 punty of Death			
Funera Directo		FORT WASHINGTON 5. Social Security Number 579-46-3319		Age (In yrs. last birtl	-	T WAS	If Under Hours		8. Date of Birt (Month, Da APRIL 24	h y, Year)		ORGES place (State or Foreign ntry) TLAND		
death with the Maryland ims 23a or 28a-f show if Falst be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE			10c. City, Town or Location FORT WASHINGTON						10d. Inside City Limits 1			
3s or 28	Il Director	10e. Street and Number 1404 OLD PISCA	10f. Z	10f. Zip Code 20744					n of What Cou	-				
ie ie	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	ned 1 ☐ Yes 2 X	1 Tyes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
21215-0036 ad within 72 hours after rgiene. for then "natural", or ite it, the Madical Exerting.	Completed	(Specify only higher (Secondary (0-12) 12TH GRADE	nt's Education est grade completed) College (1-40	le completed) (Give			dent's Usual Occupation kind of work done during most of working DO NOT use retired) CTOR				16b. Kind of Business/Industry SANITATION			
Iryland 2 ihould be filed in Mental Hygic marked other mattle event, I	To Be C	17. Father's Name (First, Middle, Last) WALTER EUGENE COLEMAN, SR. 18. Mother's Name (First, Middle, Maiden Surname) MAMIE ALICE INFZ JOHNSON COLEMAN MILLER												
timore, Ma t. Pages 1 and 2 s rtment of Health ar rtent: If item 27 ls njury or other trau	SUCE:	19a. Informant's Name/Relation MICHELLE COLEM. 20a. Method of Disposition 1 (ABurial 2 Cremation 4 Donation 5 Other (21. Schalure of Funeral Service)	3 Removal from Sta	ER 530	Disposition (Ny, crematory of	AVEN lame of r other place H.CH. (TUE, I	RIVEI 9/27/2	THE RESERVE OF THE PARTY OF THE	ARYLA 20c. Loca	AND 20	737		
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infriated events resulting in death) Last	a. Due to (or Due to (or c.	as a consequence of	Di:	fer	7 () ~	gen			Interval Between Onset and Death		
. 0 00	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death t at time of death		□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year				
	þ	Part II. Other significant condi	tions contributing to death	the underlying	and onlying dad so given in that it				d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
I Rec The law ate has b	Completed			1 □ Yes			ormed? 2 No	sy prior to completion of cause of death? 20 No 1 Yes 2 No						
E 5 5 5	tlon: To Be	25. Was case referred to medic examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves	Hospital: 1 Inp.	njury 28b. 1	tipatient 3 Time of njury M	f 28c. Injury at 28 Work?			ome 5 Resi	the conty one) ne 5 ☐ Residence 6 ☐ Other (Specify) 8d. Describe how injury occurred				
- 5550	Certification:	3 ☐ Suicide 6 ☐ Coul	minad 289. Place of	28e. Place of Injury - At home, larm, str. building, etc. (Specify)			reet, factory, office			28l. Location (Street and Number or Rural Route City or Town, State)				
Hospil 24 hour Funer stely fill.	Medical	29a. Certifier (Check only one) Certify	ring Physician: To the be al Examiner: On the basi and manner	s of examination an	a, death occurr d/or investigati	ed at the tir ion, in my o	me, date a pinion, de	nd place, ath occur	and due to the red at the time,	date and p	lace, and due	to the cause(s)		
To the within 2 To the complet	M	29b. Signature and title of certification	ler C			29c. Licens M ()		45	881	29d. Date	signed (Month	Uay, Year)		
DBL		30. Name and address of person	on who completed cause	of death (Item 23a)		any	0 "	up	20	77	7			
	State strar	31. Date liled (Months Pay, Yea	4 2004 32. Reg	istrar's Signature	Mass	No 1					·			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
September 20 **Physician** LOVEINA FELICIA 2004 8:46 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖸 F Yrs. Director 230.76.4137 76 March 29,1928 Jamaica, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road 20852 Jamaica, West Indies 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "rany injury po other treumatic event, the Med ance. Private Families College (1-4or 5+) Elementary/Secondary (0-12) 8th Housekeeper Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Dann Susan Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Jarrett/Daughter 2304 Greenery Lane, #202, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Ceme. 09/27/2004 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant. 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 1 0 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2/0 1 TYPS Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funerel Dire 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physicien: 10 the best of my knowledge, usern occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D-2766 0 30. Name and address of pirson who come lited cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20851 Alpa Goswami, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souks

DHMH 17 Rev 1/2001

Registrar

SEP 2 4 2004

Jann, Loveina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Amend#28c,perMD,FCHD,SL Certificate of Death 9/27/04 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Mary Selby Drye 3:47 P M September 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG 10 1921 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖼 F Yrs 216-14-5708 Director MD Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 E. SECOND STREET 21701 **HSA** Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 'natural' 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) MONTGOMERY CO. I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOLS LIBRARIAN 5 +traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental H BRICE P. SELBY is marked WINIFRED SNYDER ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health REBECCA BROOKS / COUSIN P.O. BOX 182, POOLESVILLE, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ita any injury or ott once. 1 Burial 2 □ Cremation 3 □ Removal from State ST. MARY'S CHURCH 9/24/04 BARNESVILLE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facilit HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIO PULMONARY Physician disease or condition resulting in death) FAILURE /Medical Due to (or as a consequence of) **Examiner** LMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner FAILURE burial-transit MULTI-SYSTEM ORGAN that initiated events resulting in death) Last certificate be execi Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Por Day Year 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown The law equires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA illed in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury a Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Medical

Records, P.O. Vital of Hospital within 24 hours a To the

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature; and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22/04 MDD0041615 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Ave Suite 303 HURT KEVIN MD

State Registrar

Pay Year) 31. Date filed (Month, E 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 16, 2004 Month **Physician** September 8:30 A M JAMES ROSS EYLER, JR. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kline Hospice House Mt. Airy Carrol1 8. Date of Birth (Month, Day, Year) Tan. 29, 1918 If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1₽ M 2□ F **Funeral** 217-01-5385 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a.f. absorption or other traumatic event, Inst Marstern 2000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 14 Yes 2 □ No Maryland Frederick Thurmont Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21788 2 North Carroll Street U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Dept. Mail Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Rudy James R. Eyler, Sr. <u>ی</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 North Carroll Street, Thurmont, Maryland 21788 Mary Jean Eyler (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/04 Bethel Cemetery Cascade, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 21. Signatura 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or com-shock, or hear failure. List only death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Therosclerotic Immediate Cause (Final disease or condition (Androvaccular Disease 20 years **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Error Uncertaing Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods Calon 3 Probably 4 Onknown deNoCARCINGMA Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificete 2 No 1 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6.20ther (Specify) Hospice 1 Yes 2 No ٩ dir this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. he 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2503515 MD 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 10 Kranth 100 5 J-L.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Division of Vital Records, P.O. Box 68760,	
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		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 4 3 9 3 0
Physic /Med	ical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Ilene Viola Edwards 2. Date of Death Month Day Year SEPTEMBER 21 2007
Exami Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County of Death 4c. County o
ы Maryland 8a-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Dorchester Hurlock 1□Yes 2☒Noc
eath with the	erai Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4452 E1wood Camp Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No
JUSD ours after d trait, or item Examiner	d by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1
BAITIMOTE, IMARYIGHO 21213-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic avant, the Moultal Examinar must be notified at anones.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seawatch Seafood Assembly Line Worker 16b. Kind of Business/Industry Seawatch Seafood Factory
aryland should be file nd Mental Hy marked oth umatic avant.	To Be (17. Father's Name (First, Middle, Last) Alonza Fletcher 18. Mother's Name (First, Middle, Maiden Sumame) Willie Mae Crumble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number City or Town State Zin Code)
ore, Mal ss 1 and 2 si of Health and itam 27 lar		Carolyn F. Jones, Daughter 4452 Elwood Camp Road, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If itam any injury or othe once.		'4 □Donation 5 □Other (Specify) Johns Cemetery Sept.25,04 Preston, Maryland 21. Signature of Furth Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death
ificate be executed g physician and as the burial-transit	dicai Examiner	Due to (or as a consequence of): Sequentially list conditions, Tarty, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): C. Due to (or as a consequence of): d.
death cert death cert e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant
- 2 8 8	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	e Completed	24a. Was an autopsy performed? performed? 1 Yes 2 No
ling Phys	ertification: To Be	25. Was case referred to medical examiner? 1
Hospital or Attending Hours after death, 4 hours after Director: Afte Funeral Director: Afte	O	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2.4 3004 Active
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** September 8:00PM 2004 21 Mary E. Fletcher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □**X**F Director 579-20-3873 81 May 26, 1923 Wash., Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Maryland Prince George's Capitol Heights Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5732 Gladstone Way 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, WAIFrican 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American þ 3 TWidowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Flementary/Secondary (0-12) 12th Domestic Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Alexander J. Diggs Bertie Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) crtent: If item 27 is Injury or other tra Sharon Ellis - Daughter 9711 Tulip Tree Dr., Mitchellville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park | 10/2/2004 Landover, MD permit.
Depirtri
Importe
any Inju 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 lutan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br heart failure. List only one cause on each line.

Immediate Cause (Final disease or countion resulting in death)

a. Approximate Interval Between Onset and Death **Physician** /Medical espending districts syndine Examiner Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 22 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 1 ☐ Yes 2 ☐ No Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1

✓ npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this After this funeral of Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours energy to the Funerel Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical ro the 29c. License number 29b. Signature and title of certifier D27521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS RL AI LEACH M.D KADLB Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 7 2004 Registrar

DHMH 17 Rev 1/2001

ETCHER, MARY

			1 - For State Registrar	State of Mary	-	artment of F rtificate of		nd Mental H	ygiene Reg. No	001	31933
	Physici		1. Decedent's Name (First, Middle, Last, Anne R. Garcia)				2. Date of D Month Septe:	Da		3. Time of Death 4 6:20P M
5	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of			. County of Dea	
			Montgomery Village Ca			Montgom	ery Vi			lontgome	ry
	Funeral		5. Social Security Number 6. Security Number 1023-14-4037	TH OTTE	n yrs. last birthday) 7 O Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Month, L	lay, Year)	l Co	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	/	79 Yrs.			Uct.	18, 1	924 Mas	sachusetts
	yland how		10a. State 10b. County	10	c. City, Town or L	ocation					10d. Inside City Limits
	e Mar	ctor	Maryland Montgome	ry	Silver S	pring					1 ☐ Yes 2 No
	vith th	Dlre	10e. Street and Number			10f. Zip Code 20904	<i>/</i> .			tizen of What Co	
	eath v	eral	2505 Musgrove Road	12. Was Decedent Ever	rin U.S. 13			in? (Specify Yes or N		ed Stat	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show tha Modical Examilian mail be notilified at	by Funeral Directo	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	10.0	If Yes, specify Cub		in? (Specify Yes or N Puerto Rican, etc.)		Black, Whit	e, etc.
21215-0036	tural'	ed b	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occur	pation		16b. K	ind of Business	/Industry
212	hin 72 in "ne	Completed	(Specify only highest grad		(Give	kind of work done DO NOT use retire	during most (d)	of working			,
21	giene gratha	E O	Lighteniary/5000mdary (6 12)	2	Homem	aker			Ow	n Home	
<u>p</u>	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					s Name (First, Middle	e, Maider	Sumame)	
<u> </u>	d Men narke	은	Henry M. Royce	imo Orinti	10h Maili	na Address (Ctroot		Spargo	har City	ne Tourn Chata	Zin Cadal
Maryland	d2st thanc thanc 17 Is n traun		Judith R. Soldano/					or Rural Route Num Clarksbu	-		
<u>စ</u> ်	Heal Heal tam 2		20a. Method of Disposition		20b. Place of Dispe	osition (Name of		Date		ocation - City or	
J O	Pages ent of nt: #1		1 ☐ Burial 2 【☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		Montgome:	matory or other pla ry ium, Inc.		eptember 4, 2004	Beth	esda, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, Its Modical Examination at the notified an once.		21. Signature of Funeral Service Licens	100 A	Ř	2. Name and Addre	ss of Facility	Robert A. 300 West	Tum; Mont	phrey Fu	ineral Home/ Avenue,
			23a. Part1. Enter the disease, or compl	lications that caused the				land 2085(ardiac or respiratory			Approximate
	Pnysician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line. Dementia	1						Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	a. Due to (or as a co							Years
п	Examiner	,	Sequentially list conditions.	b							
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
	xecution and al-tran	хап		c Due to (or as a co	onsequence of):						
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	caiE		d							
9	tificate ig phy as the	ledic		·							
Вох	leath certific attending p	an/N	23b. was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		☐Ectopic pregnanc	v			23d. Date of del	*
		Physician/Medi	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)				Month	Day Year
P.0	law requires that the as been signed by th 2 should be detache	Ph	Part II. Other significant conditions co	intributing to death but n	ot resulting in the u	ınderlying cause giv	ven in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
Vital Records,	uires tha signed I	d by	Hypoxia					1	Yes 2	□No 3□Pr	obably 4 \Quantum Unknown
COL	w requires been si	Completed						24a. Wa	s an		itopsy findings available
Re	9 4 9	отр							opsy formed? 2 X No	death?	completion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place	of Death (Check only			
of V	S 0	To	1 Tes 2 A No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	III SLI DOA		sing Home 5 🗆 Re	sidence	6 □Other (Spe	cify)
	ding P	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wo	rk?	28d. Describe	how inju	ry occurred	
Division	t or Attending after death. Diractor: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st]Yes 2□N		(Street ar	nd Number or Ri	ural Route Number,
Di∧	after Dirac	Certification:	4 Homicide determined	building, etc. (5	Specify)	root, radiory, omoo			own. State		,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	/sician: To the best of m iner: On the basis of exa and manner stated	amination and/or ir	th occurred at the ti	me, date and opinion, death	place, and due to the occurred at the time	e cause(s e, date and) and manner as d place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and the of certifier			29c. Licens	se number		29d. Da	te signed (Mont	h, Day, Year)
)			トカたん	John _	_	D2014	8		Sept	ember 23	3, 2004
	(0		30. Name and address of person who ca								
			Steven H. Dolinsky			Avenue,	Gaithe	rsburg, M	D 208	879	
	Sta Registi		31. Date filed (Month, Day, Year) SFP 2 4 200	32. Registrar's	P.	Sparks	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 per Th 2845 7-18-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1- For PHY C836 in Ode 10 A.S. Reg. No. CCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2004 03:35 September reillic 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Johns HOPKINS Baltimore City
If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 222-14-8245 Months Days 12 M 2 F 10 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show traumatic event, the Mudical Examiner aust be nutified at DE 1 Yes 2 No Dover Director Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 19904 Richard 13asse US A 293 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 □ No If Yes, Give 1 Never Married 2 Married Specify: White 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Playtex Export / shipping 11 18. Mother's Name (First, Middle, Maiden Sumame)
Coral Thornburgh 17. Father's Name (First, Middle, Last) Be James Gray Brady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s Health ar Basse++ Gray - Wife Richard Rd. Dover, De Eva Hem 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any injury or off 2000. 1 ■ Burial 2 Cremation 3 Removal from State 9-24-04 Camden. DE Odd Fellows * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee William Covelly lut TORBERT FUNERAL CHAPEL, DOVER, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY EDMA Immediate Cause (Final **Physician** 2 dem disease or condition resulting in death) /Medical Due to (or as a consequence of): NEPHROTIC SYNDRONE Examiner 6 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 HNO 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei C 1 C-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 2 September 22,2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Escher Hopking Hospital Toner 110, Doctor's Lounge GOON ath wolfe Sheet Baltime, MD 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 4 2004 1934 Registrar

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Examine		4a. Facility Name (If not institution Peninstitution Apg)		nd number)	Cons	1			Location o			4c.	County	of Death	0	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under	1 Year	If Under 2		8. Date of Birt (Month, Da	h		9. Birthola	ace (Star	te or Foreign
Director		215-01-3270 Usual Residence of Decedent	1 🔀 M 2] F	89	Yrs.	Months	Days	Hours	Min.	DEC. 23	y, Year) , 19	14	Count	RYLA	-
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Attending Physiclen: r death. ector: Attenting by the funeral director.	OU	27. Manner of Death 1—Natural 5 Pend	ing	Date of Inju. (Month, Da	ry Yea <i>r)</i> 28b.	Time o		8c. Injun Worl			28d. Describe I	now injury	occurre	ed .		
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or At fter c lirect n by	Certification;	4 Homicide deter	mined 28e.	. Place of Injude in the Building, etc.	ury - At home, f c. <i>(Specify)</i>	arm, st	treet, factory	, office			28f. Location (: City or To	otreet and vn, State)	a Numbe I	or Or Rural	Route ∧	lumber,
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5 1× 5 00	-	250. Signature and title of certif		11			290		3 A.2	(>		Lou. Dati	y signed	(Month, E	ay, rea	/

Division of Vital Records, P.O. Box 68760,

0,20

Baltimore, Maryland 21215-0036

215013270

State Registrar

31. Date filed (Month, Day, Year)
SEP 2 4 2004

completed cause of death (Item 23a) (Type, Print)

(IV CA TV M) PENINSULA REGIONAL MEDICAL

2004

32. Registrar's Signature

B Aparks

29c. License number

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Anna M. Hoch muth 09 22 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ancharage Mursing + Rehabilitation
5. Social Security Number 6. Sex 7. Age (In vis. last binh) If Under 1 Year If Whoter 24 Hrs. 8. Date of Birth (Month, Day, Wicomico 7. Age (In yrs. last birthday) **Funeral** Vearl 1 ☐ M 2**K**) F Director 251-32-7973 78 May 14, 1926 Missouri Usual Residence of Decedent Peges 1 and 2 should be flied within 72 hours after deeth with the Maryland nent of Health end Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exeminer must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10137 Snethen Church Road 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Frank Henson Jennie Billingslev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) 10137 Snethen Church Road, Delmar, Maryland John A. Hochmuth, Sr. 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges
Department of
Important: If it
any injury or o 1 PBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Springhill Memory Garden September 24, 2004 Hebron, Maryland 22. Name and Address of Facility
Holloway Funeral HOme Professional Association
C(-SP 501 Snow Hill Road, Salisbury, Maryland 21804 ative of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition **Physician** Mydoma 242915 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of defivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certification of the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2√No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2rl natu DO 51359 September 22rd 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415. S. DIVISION SAUSBURY Dr. 45HA NATESAN 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State SEP 2 3 2004 Registrar

Carlton H _04-6092 AKG	ICT.	Unpend Ite		_				- 2001	e.
	_	Registramend#16a 1. Decedent's Name (First, Middle		-04-04 C	ertificate of	Dealli	2. Date of Death	g. Nó, 🕖 🕖	3. Time of Death
Physic			ERRETT				Month September	•	ear A A C D M
/Med Exami		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of	
C		Peninsula Regio	nal Medical	Center	Salisbu			Wicom	
Funera Director		5. Social Security Number 534-24-7873	350	73 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/20/1	931 X	Birthplace (State or Foreign ASHTINGTON MCTICA
Du ≱		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
burs after death with the Marylan raf, or Items 23a or 28a-1 show	Director	Md Wicom	ico		haven				1 Tyes 2 No
with the growth of the present		10e. Street and Number			10f. Zip Code			g. Citizen of Wha	ŕ
eath ns 23	era	23848 Riv	er Street 12. Was Decedent	Ever in U.S. 13	218 3. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		States American Indian,
36 rs after d r, or iten	by Funeral	1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:	Nat'I No Guard	If Yes, specify Cuba 1 ☐ Yes 💥 No	an, Mexican, Puert Specify:	o Rican, etc.)	Black,	White, etc. White
72 hours aft	edt	15. Deceden	t's Education	16a. Dec	cedent's Usual Occup	ation	1 1	6b. Kind of Busin	
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lan lid be fental rked	To B	Norman Angli	n			Manerv	a Whee	1on	
Laryla 2 should and Men Is marke		19a. Informant's Name/Relations		19b. Ma	iling Address (Street				ate, Zip Code)
	13	Maryen Herre	tt,Wife		48 River	St.,Wh			
altimore, mit. Pages 1 ar portment of Hea portant: If item		20a. Method of Disposition 1 🗆 Burial 🌋 Cremation	3 □Removal from State	cemetery, c	position (Name of rematory or other place				ty or Town, State
Baltimor		* 4 □ Donation 5 □ Other (S	pecify)	Salisb	ury Crem	, -			ry, Md.
Bal Dermij Depar mpor mpor		21. Signature of Funeral Service	M90-41	17	22. Name and Addre	Funera	1 Home,	P. 0 ,61	
		23a Part 1 Enter the disease, or	complications that cause	d the death. Do not e	Bivalve	, Md 21	814 or respiratory arre	st.	Approximate
Filleros		23a. Part1. Enter the disease, or shock, or heart failure. List						,	Interval Between Onset and Death
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Examine				a somodasmo sij.					
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Beatte death	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	
P.O.	Ph/	Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause giv	ven in Part I	23a. Did tob	acco use contrib	ute to the cause of death?
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be or	d by				anasnying saass gr				Probably 4 Junknown
Cords w require s been sig	lete						24a. Was ar		ere aulopsy findings available
I Re(The lay	Completed						autopsy perform Yes 2	red? qea	or to completion of cause of ath? DYes 2 □ No
Vital Fician: The certificate	0	25. Was case referred to medical	ı _			26. Place of De	ath (Check only one		J. 60 ELINO
f Vita nysician: nis certific director,	To B	examiner? 1 X Yes _2 ☐ No	Hospital: 1 Inpat	ient 25ER/Outpat	tient 3 DOA	ner: 4 🗆 Nursing F	lome 5 Reside	nce 6 Other	(Specify)
on of ding Phys After this funeral di		27. Manner of Death 1 Natural 5 Pendi	28a. Date of Inj	ury 28b. Time 4:05		ry at rk?	28d. Describe ho	w injury occurred	1
isiol ttendii death. ctor: A y the fu	catle	2 Accident invest	not be found	foun	d P	Yes 2X No	subject		
Division at or Attending s after death. I Director: After	Certification:	3 Suicide 6 Could 4 Homicide detern		njury - At home, farm, otc. <i>(Specify)</i> ICC	street, factory, office		28f. Location (Str City or Town Whitehay	eet and 2384 State) Mar	4 ^{r R} K1Ver "St ^{er} yland
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		ng Physician: To the bes Examiner: On the basis and manner s	of examination and/or	eath occurred at the ti	me, date and place opinion, death occi	e, and due to the ca	use(s) and mann	ner as stated.
o the ithin . o the	Mec	29b. Signature and title of certific			29c. Licens	se number	29	d. Date signed (Month, Day, Year)
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		30. Name and address of person	who completed cause of	d av (Item 23a) (Tyr	pe, Print)				
			Miking	17 - T		n Street	Baltim	ore. Mar	yland 21201
	tate	31. Date filed (Month, Day, Year		trar's Signature			· · · · · · · · · · · · · · · · · · ·	بالمالات و سود	7
Regi	strar	OCT 0.4	2001 Nen	wa &	Soork				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year SEPTEMBER 24,2004 HUBBLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHARLES COUNTY NURSING & REHAB CTR. LA PLATA CHARLES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖼 F Yrs. 219-92-3264 Director 78 December 23, 1925 Italy Usual Residence of Decedent 10b. County 10c. City, Town or Location itam 27 is markad other than "natural", or Itams 23s or 28a-f show other traumatic evant, the Medical Evaninar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11505 Tyre Street 20772 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "" any injury or other traumatic avant the service of the Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emilio Fondi Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Angela McConkey / Daughter 8200 Tiverton Dr., Port Tobacco, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 9/28/2004 Clinton, Maryland 21. Signature of Fineral Service Coensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular Accident Priysician Cerebral /Medical Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or a a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlipidemig 1 ☐ Yes 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Uversing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 28d. Describe how injury occurred 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aring MD tames DO0 52917 30. Nam and address of person who ampleted cause of death (Item 23a) (Type, Print) James I. Harring, M.D. 102 Centennial St., Suite 102 LaPlata, MD 20646 State SEP 2 7 2004 Registrar

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/Medic		4a. Facility Name	(If not institution	n, give street and n	number)		4b. City, Town, or	Location of			4c. County of	
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uneral irector		5. Social Security 214–36–2		6. Sex 1 ☐ M 2 X F		yrs. last birthday, Yrs.	Months Days	If Under 2	Min /	Date of Birth Month, Day, Yea 19 18,19	9	. Birthplace (State or F Country)
ii ectoi		Usual Residence			- 07				Ma	y 10,19	3/ M	D
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a or 2	ă	10e. Street and Nu		_			10f. Zip Code			10g.	Citizen of Wha	at Country?
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			Decedent's Name (First, Middle, Last)	2. Date of Death	_	3. Time of Death
	Physici /Medio		TO ANOTO MADIA TANG HANNA	Month	Day Year	12:30 PM.
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	,
			SACRED MEARY MOSPITAL Comberland		Alle GAI	
	Funeral		5. Social Security Number 216 22 5510 6. Sex 1 M 2 F 79 Yrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Mi	8. Date of Birth (Month, Day, Y JULY 8 1	9. Birthp	lace (State or Foreign
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	yłand 10w		10a. State 10b. County 10c. City, Town or Location		1	Od. In side City Limits
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	ath w	ra	100 WRIGHT STREET 21532		U.S.	
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	irs aff	by F			Specify:	√HITE
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show udical Examinational be netlified at			16	b. Kind of Business/Ind	
21	d within 7 giene. ir than "r the Med	Completed	(Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)	ng		
2	70 00 =				OWN HOME	
land	be do do	To Be	17. Father's Name (First, Middle, Last) ALONZO MIDDLETON 18. Mother's Name FRANCE	<i>(First, Middle, Ma</i> SFILER	iden Sumame)	
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) GLEN U. HANNA / HUSBAND 19b. Mailing Address (Street and Number or Rural) 100 WRIGHT ST. FROSTBU			Code)
	1 an Heall am 2 thar	1			c. Location - City or To	wn State
Baltimore,	0 0		1 XBurial 2 Cremation 3 Removal from State '* 4 Donation 5 Dother (Specify) FROSTBURG MEMORIAL PARK 10/		OSTBURG, MI	
ati	그 된 본 글		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		60 W. MAIN	
ă	Deprement Deprem		SOWERS FUNERAL HOME		FROSTBURG,	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sequentially list conditions, Due to (or as a consequence of): Lung Abs (esses - bi)	1.1.	/	10%
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate b	148884	/	May
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9	eath certific attending p	/Med	IF FEMALE:			
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of deliver Month	y Day Year
o.	at the de by the a tached	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			
٣.	res that igned b be deta	by Pt		23e. Did tobac	co use contribute to the	e cause of death?
Records,	w require been sig should b			1 🗆 Yes	2 □No 3 □ Proba	ably 4 □Unknown
000	e law re has be je 2 sho	Completed	Chronic anemia	24a. Was an autopsy	24b. Were autop	sy findings available
Œ		Con	Perigheral Vascula- disease	performed	d? death?	2□ No
Vital	Physician: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	(Check only one)		
of	Physic this cral dir	은	Thursday Home		e 6 Other (Specify)
n	ling After fune	lo l	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? 28 Accident investigation 28b. Time of Injury Work? 1 Yes 2 No	8d. Describe how	injury occurred	
Division	deat deat stor: the	flca	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28	8f. Location (Stree	at and Number or Rural	Route Number
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	\$ 7 <u>8</u> 7		The second secon	>	Date signed (Month, E	ay, rear)
7	_		30 Namp and address of person who colorgisted cause of death (Item 23a) (Type, Print)	21	9/28,	07
	5		INOMAS E CUMMII MD 912 Setus D- 1	'umb	Vand	MD
	Sta		10 Mas = (May M) 917 Seton D - (31. Date filed (Month, Day, Year) OCT 0 8 2004 Seton D - (OCT 0 8 2004			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 30, 2004 1:00 A M George Richard /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth
(Month, Day, Year)
Sent. 4, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Hours X M 2 □ F 214-32-4326 71 Director Yrs. Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, It a Medical Examinal must be notified at Marvland Frederick Emmitsburg Director 1 XYes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 230 DePaul Street 21727 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or them any injury or other traumatic event, It at Medical Exercitors once. Black, White, etc. X Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) Farmer/Mill Worker Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles William Henry Hanes Helen Mae Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Wivell, sister 230 Depaul St., Emmitsburg, Maryland 21727 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory Oct. 1, 2004 Smithsburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility ford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Deard disease or condition resulting in death) /Medical Due to for as a consequel Examiner Sequentially list conditions, Due to (or as a openagouence of) Examiner if any landing to immedicause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed? res 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 HOUSE 212,MD OLL 31. Date filod (Month, Day, Year) 32. Registrar's Signature State OCT 0 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Daniel I. Hummer September 29.2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 8. Date of Birth Mar 3, 1921 Birthplace (State or Foreign Country) PA 1 □XM 2 □ F Months 196-14-1627 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA Franklin Rouzerville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11920 Broad St. 17250 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck driver Trucking company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Solomon D. Hummer Bertha Mae Sites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Youse daughter 1930 Pleasant Grove RD Box 105, Needmore, PA 17238 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Salem Ridge Mennonite Ch. Oct. 4, 2004 Greencastle, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington ST Greencastle, PA 17225 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death mediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Meumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Renal Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thinknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or Items 23a or 28a-f show If a Modical Exprise er must be notified at

il Hygiene. other than "

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked othe any injury or other traumatic event, once.

hours after

Baltimore, Maryland 21215-0036

Director

Funerai

þ

Completed

Be

burial-tran the attending pl detached ģ signed I has

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital within 24 hours a To the Funeral L

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner

Be

Certification: To

Medical

page 2 s this certificate funeral director, After s after dec.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No □Yes

> 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D0060396 29d. Date signed (Month, Day, Year) 09/30/0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSHED

FARID 31. Date filed (Month, Day, Year)

OCT 0 8 2004

32. Registrar's Signature

MI

Opal Coust Hog. Md

State Registrar

filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Hose Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** icspital Allegan 8. Date of Birth Month Day, Year) 7, 1915 sored If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex yrs. last birthday, Min 1 □ M 2 🙀 F **Wit** Yrs. 216-90-4310 89 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Allegany Cumberland MD 1√Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Furnace Street Ext. 21502 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha (Boward) Hose Joseph R. Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) socworker P.O. Box 1420 Cumberland MD 21502 Susan Bambacus 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Temation 3 Removal from State Scarpelli Funeral Home, P.A. 10/1/2004 Cresaptown MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral/Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Due to (or as a conseque IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

/Medical **Examiner** Hospital or Attending Physicien: The law requires that the death certificate be executed Box 68760 physician for use as P.O. page 2 should be detached Division of Vital Records, the funeral director, efter death. filled in by

Examiner Physician/Medical by Be Completed Certification: To Medical

within 24 hours e

Funeral

Director

or items 23a or 28a-f show

treumetic event, the Medical Exacting must be notified at

"natural"

than

Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tent: If item 27 is marked other th jury or other treumetic event, its

Department of Importent: If eny injury or once.

Physician

filed within 72 hours after death

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00 8377

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUMBERLAND MD 924 Seton VELANDIA MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) OCT 0 8 2004

6 Could not be

32. Registrar's Signature

			1 - For Stete Registrer	State of	Marylan			t of H	ealth an	d Mental I		0001	3191.1.
	Physicia /Medic		1. Decedent's Name (First, Middle, La: Martha R. Jen							2. Date of Month Sept	Da		3. Time of Death 10:03 PM
	Examin		4a. Facility Name (If not institution, give		per)		4b. City,	Town, or	Location of D			. County of Dea	ith
			#30 Old Farm 1 5. Social Security Number 6. S		. Age (In yrs. I	lact hirthday	Ear	1ev	ille If Under 24 F	Hre o Data at	Diah	Ceci1	
	Funeral Director		159-01-2393	M 2□X	87		Months	Days		Ain. Sept	Birth Day, Year,	1916	thplace (State or Foreign ountry) PA
	yland Now		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	e Mar He-f st	ctor	MD Cecil		E	arlev	ille						1 □ Yes 2X No
	with th	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Ci	tizen of What C	ountry?
	leath v	eral	#30 Old Farm 1	Road 12. Was Deced	ent Ever in U	S 13 1		919	spanie Origin?	(Specify Ves or		14. Race - Am	arican Indian
ဖ	after d or iten		1 Never Married 2 Married	Armed Forc 1 ☐ Yes 2	es? XNo					? (Specify Yes or uerto Rican, etc.)) NO.	Black, Whi	te, etc.
000	urel', c	d by	3 MWidowed 4 □ Divorced	If Yes, Give Year or Date	es:		1□Yes 2	ZKI No	Specify:			Specify: W	nite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, it a Marical Examination that the must be routiled at once.	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	k done d	uring most of	working	16b. K	(ind of Business	/Industry
212	d with giene.	omo	Elementary/Secondary (0-12)	College (1-4	lor 5+)				etary		F	ducati	ion
ם	be file tal Hy d othe	Be C	17. Father's Name (First, Middle, Last)							Name (First, Mio			
Maryland	J Men J Men narke	2	Warren H. Rupe				- 11			Fa1cor			
<u>s</u>	od 2 sl Ith and 1 st 27 is r r traur		19a. Informant's Name/Relationship (Brent Jenkins,							Rural Route Nu ad, Ear			
ore,	ss 1 and 2. of Health ar item 27 is r other trau		20a. Method of Disposition		1 00	lace of Dispo	sition (Nam	te of		Date	20c. L	ocation - City or	
Ē	Page ment cent: if ent: if ury or		¹X Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify		ate				, per	ot. 27, 2004	Ea	r1evi1	lle, MD
Baltimore,	permit. Depart Import Import Seny in		21. Signature of Funeral Service Licer	See V		22 A	. Name and	d Addres W G	s of Facility • Gee	Funera	1 Ho	me	
	20200		23a. Part 1. Enter the disease, or com	plications that cau	ised the death	2	59 E	ast	Main	St. I	Tikto		21921 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ead	h line.			,			, 2		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or	as a consequ	uence of):							
	LAditifiei	<u>.</u>	Sequentially list conditions,	b. Pue to for	as a consequ	ianco of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D09 00 (01	as a consequ	ierice or).							
Ó	a exectan and and and and and and and and and a		resulting in death) Last	Due to (or	as a consequ	ience of):							
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9 X	it the death certifica by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar	ncv						001 0 (1	
. Box	death e atter	iciar	in the past 12 months?	1□Live birtl 4□Pregnan	h 2 ∐ Fetal ntat time of de	death 3	Ectopic pre Other (spe				_	23d. Date of de Month	Day Year
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a	ysicien: The i is certificate ha director, page	BeC	25. Was case referred to medical examiner?						26. Place of [1 ☐ Ye Death (Check on		1 □ Yes	2□ No
<u>></u>	Physicien: r this certifica ral director, p	ို	1 ☐ Yes 2 No		patient 2 2				4 U Nursing	g Home 5 R	esidence	6 □Other (Spe	cify)
o	Jing After fune	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month,	Day Year)	28b. Time of Injury	м 28	Bc. Injury Work	at ? es 2. Mo	28d. Descrit	be how inju	y occurred	
Division of Vital Records,	Attending or death. octor: After by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho	me, farm, str			03 212110	28f. Locatio	n (Street ar	d Number or Ru	ıral Route Number,
۵	itel or rs efte el Dire	Cert	4 Horricide	building	, etc. (Specity					City or	Town, State)	
	To the Hospitel or Attending Phwitin 24 hours eiter death. To the Funerel Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) (Check only one)	ysician: To the bo niner: On the basi and manner	is of examinati	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and pla inion, death or	ace, and due to t ccurred at the tim	he cause(s) ne, date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c.	License	number		29d. Da	te signed (Monti	h, Day, Year)
			1 tal	~~)			O	00543	27	00	1/24/20	04
	10		30. Name and address of person who	_				~ ~	34-	Cala			
	Sta	te	31. Date filed (Month, Day, Year)	32. 9 99	istrar's Signat	west-	MISH	24. ;	ne siz	Elliton	WD	21921	
	Registr		SEP 242	004	istrar's Signat	K A	مكام						

	,		1 - For State Registrar	State of Ma	aryland /		nent of F		ind Me		iene _{9. Nó.} ()	04	31945
Е	Physici	an	Decedent's Name (First, Middle, L.	ast)						. Date of Deat Month	th Day	Yeer	3. Time of Death
	/Medic		JOHN HENRY 3							09	22	2004	10450 AM
	Examin	er	4a. Facility Name (If not institution, gi	2.4		4b	City, Town, o	r Location of	f Death			y of Death	
			THE MEMORIA	L HOSPITA		hinth days) If	Under 1 Year	If Under 2	24 Hrs o	. Date of Birth		LBOT	
12.5	Funeral Director		5. Social Security Number 6. 140–24–9381	18 M 2□F 7. Ag	e (In yrs. last 82		nths Days	Hours	Min.	(Month, Day)	Year)	9. Birth	olace (State or Foreign ntry)
No.	- AF		Usual Residence of Decedent		02				L	750 3 1	741	GER	MANY
	how		10a. State 10b. County		10c. City, To	own or Location							10d. Inside City Limits
	the Marylar 28a-f show	by Funeral Director	MD TALBO)T 		EAST	ON						Y☐Yes 2☐No
	or 2	Dire	10e. Street and Number			1	of. Zip Code			1	0g. Citizen of	What Cou	ntry?
	after death w or Items 23s	rai	413 S. HANSON	1			216					USA	
	er de Rem	une	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of H s, specify Cuba	lispanic Orig an, Mexican,	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		ce - Ameri ack, White,	
36	rs aft	oy F	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 ☐ I If Yes, Give Year or Dates:	NO	1 🗆 '	es 2XI No	Specify:			Spec	ity: WE	IITE
5-0036	n 72 hours after death with the Maryland "natural", or ftems 23s or 28s-f show sdical Examinar must be notified at	ted	15. Decedent's f	ducation	10	6a. Decedent'	Usual Occup	ation			16b. Kind of I	Business/In	dustry
215	within 7; ene. than "n	pie	(Specify only highest g. Elementary/Secondary (0-12)	rade completed) College (1-4or 5	5+1	(Give kind life. DO N	of work done	during most d)	of working				,
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Maryland	2 2 2 2		19a. Informant's Name/Relationship JUDITH J. FAUNTL		1	19b. Mailing Ad				Route Number			Code)
-	s 1 and of Health item 27 other tr		20a. Method of Disposition	EROI/NIECE	20b. Place	of Disposition		1 KD.,	Dai		20c. Location		num State
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687	equires that the death certificate sen signed by the attending phys tould be detached for use as the	edicai		d									
	leath certifica attending ph	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	,					23d D	ate of deliv	90/
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0	res that the de signed by the a be detached t	hys	9 Unknown	9□ Unknown									
ď	gned gned e det		Part II. Other significant conditions	contributing to death b	ut not resultin	g in the under	ying cause giv	en in Part I.		23e. Did tot	oacco use cor	ntribute to t	he cause of death?
ğ	w require been sig should b	ed	Hypoalbuniv	ema						1 □ Ye	s 2 🗆 No	3 🗌 Prot	Dably Dunknown
Records,	as by	Completed by	Decubitus	ulcers						24a. Was a autops		Were auto	ppsy findings available impletion of cause of
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Ž	hysic this co	2	1 ☐ Yes 2 XNo	Hospital:			DOA Oth	er: 4 🗆 Nur	rsing Home	5 ☐ Reside	ence 6 □Ot	her (Specii	(y)
n	nding Physician: ath. r: After this certific e funeral director,	O	27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28	b. Time of Injury	28c. Injur Wor			d. Describe ho	w injury occu	rred	
Sic	tend death tor: /	cat	2 Accident investigate 3 Suicide 6 Could not	he	At barra			Yes 2□N					
Division of Vital	after of Direction by	Certification:	4 Homicide determine	d 28e. Place of Inj building, et	c. (Specify)	, tarm, street,	actory, office		28	City or Town	reet and Num n, State)	iber or Hura	al Route Number,
	Hospital 4 hours a Funeral i		29a. Certifier Certifying F	hysician: To the best	of my knowled	dge, death occ	urred at the fir	ne. date and	d place, an	d due to the ca	ause(s) and n	anner as s	tated
	e Hos	edical	(Check only 2 Medical Executed one)	eminer: On the basis of and manner st	f examination	and/or investi	gation, in my o	pinion, deat	h occurred	at the time, d	ate and place	, and due to	the cause(s)
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	Me	29b. Signature and title of certifier		10		29c. Licens			_	9d. Date sign		
•) Labhmi	Vandya	natho	m M ()	00	57	74	5 5	erten	BER	22 2004
			30. Name and address of person wh	completed cause of c	leath (Item 23	Ba) (Type, Prin)						
			LAKSHMI VAIDYNE				IGTON S	T EAST	TON,	MD 2160)1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		ar's Signature	1 4	i.						

DHMH 17 Rev 1/2001

Jacoas, John

		1	For State Registrar	State of Ma	arylan	•	artmen tificat			and Me	, ,	iene	04	31946
l I	Physicia		1. Decedent's Name (First, Middle, La	•							2. Date of Deal		Year .	3. Time of Death
5	/Medic	al -	Gloria 4a. Fecility Name (If not institution, gi	Johnson			4h Cihi	Town or	Location of		eptemb	er 19	2004	20:18 P M
	Examin	er	Prince George's				4b. City,		ever1					George's
پ	Funeral Director		Social Security Number 6.			last birthday) 72 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. 8	B. Date of Birth (Month, Day,		9. Birtho	place (State or Foreign
	D		Usual Residence of Decedent		10- 0'-	-				1				
	e Maryla 3a-f shov	Director	DC 10a. State 10b. County		100. 01	y, Town or La	cation	W	ashin	gton				0d. Inside City Limits 1
	th with th	ai Dire	10e. Street and Number 836 - 50th P	lace, N.E.			10f. Zip	Code	200	19	1	0g. Citizen <i>o</i> f t Un		ntry? States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 23a-f show important: if Item 27 is marked other than "natural", or Itema 23a or 23a-f show important; if Item 27 is marked other than the modified at an injury or other traumatic event, the Madical Exemples mail be modified at angle.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or No- ican, etc.)		ck, White,	ean Indian, etc. Lack
2-0	72 ho	eted	15. Decedent's E (Specify only highest g			16a. Dece	kind of wo	rk done d	turing most	t of working	9	16b. Kind of B	usiness/In	dustry
Maryland 21215-0036	within ene. then "	Completed by	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	life.	DO NOT us	se retired)	ovide		Se1	f-Emr	oloyed
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ylar	Menta Menta arked atic s	To E	Howard Russ					To the second se			Evely	n Smith		
Mar			19a. Informant's Name/Relationship Teresa Robinson/		tor							r, City or Town, arlboro		20774
altimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or othar tra <u>QDCE</u> .		20a. Method of Disposition 1 ऄ Burial 2 □ Cremation 3			Place of Dispo				Da		20c. Location	_	
ii m	Page tment tant: It		* 4 □ Conation 5 □ Other (Spec	ify)	Qı	uantic					2004 _	Tri	angle	, VA
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			23a. Part 1 Enter the disease, or conshoot, or heart failure. List only	mplications that caus	the deat	th. Do not ent						Wash., est,	DC 2	20019 Approximate Interval Between
8760,	death certificate be executed Medical and the executed of attending physician and a strength of tor use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to (or as Due to (or as d.	a conseq	quence of):		4r le	OVAS	anas	1 IT CO	n Wis e	2,9	
O. Box 6	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	al death 3	∃Ectopic pi ∃ Other (<i>sp</i>						te of delive	ery Day Year
ds, P	res that the signed by th I be detache	by	Part II. Other significant conditions	contributing to death t	out not res	sulting in the u	nderlying o	ause give	en in Part I.			_		ne cause of death?
200	law requires as been sign 2 should be	ietec								_	24a. Was a			psy findings available
Vital Records,	The ate ha	Completed								_	autops perfori	sy med?		mpletion of cause of 2□ No
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	. V] ER/Outpatier		Othe	0.0		(Check only on		_	
of	9 Phys er this eral di	n: To	1 Tes 2 No 27. Manner of Death	1 ☐ Inpati	ıry	28b. Time o	_	28c. Injun World	4 🗆 140			ence 6 Othow injury occur		y)
ion	Attending Indeath. Sector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigati		ly Year)	Injury	М		<br Yes 2 □i	No				
Division	- 0 -	Certification;	3 ☐ Suicide 6 ☐ Could not determine				reet, factor	y, office		28	Bf. Location (Si City or Town		er or Rura	I Route Number,
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	edical (29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, ar th occurred	nd due to the c d at the time, d	ause(s) and ma late and place,	anner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11			290	c. License				9d. Date signe		•
			Caroda	14/13	100,	30		150	253	927		Sytem	Jace	22, 2004
(J (4)		30. Name and address of person who	o completed cause of	death (Iter	m 23a) (Type,	Print)	0,24	٠. (Ches	iel.	Sytem	c/100	J d
		ate	31. Date filed (Month, Day, Year)		rar's Signa	ature	٠. مد		/	V	71	/	1	
	Regist	I d.I	SED 2 7 20	UT 1777.5E		S Link	47							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of N	naryiai		tificate			vientai Hyg R	iene _{sg. No.} 2 1	O.L.	2101	7
	Dhusisi		1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h	Vin	3. Time of Deal	th 2
	Physici /Medic			Larry Tho	mas .	Jenkins				Septembe	Day	Year 2004	9:11 A	М
7	Examin		4a. Facility Name (If not institution,	give street and number	r)			4b.	City, Town, or L	ocation of Death	4c. County			
			Frederick Memor						rederic		Frede	rick		
	Funeral Director		5. Social Security Number 223-82-7506 Usual Residence of Decedent	5. Sex 1 M 2 □ F	ige (In yrs. 50	last birthday) Yrs.	If Under 1 Y Months Da		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 5,	1954	9. Birthpl Count Texa	ace (State or For lry) IS	ei g n
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation			~~~		10	d. Inside City Lin	nits
	Mary First	ģ	W Jeffer	son	Ch	arles T	ำ (พิทา						11√2 Yes 2□	No
	r 28c	Funeral Director	10e. Street and Number	3011	O. I.	arred 1	10f. Zip Cod	de		10	Og. Citizen of	What Count	ry?	
	th wit	aD	913 Belveder	Drive			2541	4				USA		
	ems	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	I,S. 13. V			anic Origin? (Sp	pecify Yes or No- Rican, etc.)		e - America		
21215-0020	within 72 hours aftar death with the Maryland ena. than "netural", or items 23a or 28a-f show he Medical Examinar must be notified at	ρ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4√2 Divorced		No No		☐ Yes 2 🔀		Specify:	nican, etc.)	Specify	ck, White, e V: Whi		
5-0	72 hc	ate	15. Decedent's (Specify only highest	Education		16a. Deced	ent's Usual Ockind of work de	ccupatio	on on most of wor	kina	6b. Kind of B			
21	I within 72 ho liena. r than "netur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)				ing most of wor	(III)				
2	77		17. Father's Name (First, Middle, L	4		Suppl	y Mana	-					anization	
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2	d 2 should th and Men 7 is marke traumatic	ဥ	19a. Informant's Name/Relationsh		15	10h Mailin	a Address /St	mot an		Laura Gri		Cto to Zin i	On do l	
Z	d 2 ha			, , , , , , ,									,00e)	
ē	s 1 and of Health item 27 other to	1	Annie L. Jenkins 20a. Method of Disposition			Place of Dispos	sition (Name o	of .	- Harpe	ers Ferry	Oc. Location -	City or Tov	vn, State	
E	age ento t: if y or		1 ☐ Burial 2 ☑ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		9	cemetery, crem agers to	•		orv	9/27/04	Hagers	t own	MD	
Baltimore,			21. Signature of Funeral Service Li				Name and A		of Facility					
<u> </u>	parm Depa Impo any ii		PRAT L	Spen					Han	ckles-Spe pers Fer	rv. W			
	5.		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	ed the deat line.	th. Do not ente	er the mode of	dying,	such as cardiac	or respiratory arre	st,	- 1	Approximate Interval Between Onset and Death	
J	Physician /Medical		Immediate Cause (Final	Acle	200			_	0- 21-	0	D' ca	1		
П	Examiner		disease or condition resulting in death)	a. MY TC		or as a consequ		201	diova	scular	101869	22	Years	
	n =	ner			Dao 10 (1	or as a consequ	derice ory.							
	rifficete be executed ng physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (d	or as a consequ	uence of):							
68760,	be ex	alE	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
687	ficete phys	Medical	resulting in death) Last		Due to (d	r as a consequ	ience of):							
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	death cer ne attendir ed for use	icia	Part II. Other significant condition	s contributing to death	hut not res	ulting in the un	dedvina cause	a diven	in Part I	22h Did tol	2000 1100 00	ntribute to	the causa of dea	n4h-2
P.O.	ach tha	Physician/	artin outside of the control of the	o contributing to dout	Dat Hot 163	diting in the di	derlying cause	giveir	mran.				ably 4.⊠*Unkn	
	as the gned be de	þ												
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ec	2 s t	Completed										of de	pletion of cause eath?	
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Vital	ician: Th cartificata ractor, pag	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of Deat	h (Check only one)			
5	dis S	<u>۲</u>	1 Yes 2 No 27. Manner of Death	i ⊔ inpat		ER/Outpatient 28b. Time of	OL DON	Other:		ome 5 Resider		1 1 27		
o	dlng h. After fune	햩	1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, D	ay Year)	Injury		Injury at Work? 1 □ Yes	s 2 🗆 No	200. Describe no	w injury occur	ed De		
Division	Attending r deeth. octor: After by the fune	E Ca	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Ir	njury - At h	ome, farm, stre				28f. Location (Str.	eet and Numb	er or Rural	Route Number.	
á	tal or rs afta al Dire	Certification:	4 ☐ Homicide determin	building, e	tc. (Specif	y)				City or Town,	State)			
	To the Hospital or Attending Pr within 24 hours aftar deeth. To the Funeral Director: After th completaly filled in by the funeral	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminar: On the basis and manners	of examina	wledge, death tion and/or inve	occurred at the	e time, ny opini	date and place, ion, death occur	and due to the cared at the time, da	use(s) and ma te and place,	inner as sta and due to t	ted. he cause(s)	
	Vithin Fo the	Me	29b. Signature and title of certifier	> 1			29c. Lic	ense ni	umber	29	d. Date signe	d (Month, D	ay, Year)	
	, - 0		MANONI	0 8	~	11	D	35	164				7,2004	_
			30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type, F							.,	
_	/		Andrew Zarick,					Fr	ederick	, MD 217	01			
	Sta		31. Date filed (Month, Day, Year)	32. Regist	trar's Signa	iture 4				,			_	
	Registr	air	SEP Z	/1814	1	\sim	and	2K	1/					

			For State Ragistrar	State	of Maryla	•		nt of He		nd Me		giene Reg. No. 2	2001	0.1	010
	Physicia	200	Decedent's Name (First, Midd.	le, Last)						1	2. Date of Dea		Year	3. Time o	
	/Medic				nson						Septemb	er 2	2, 200		15 P ^M
	Examin	er	4a. Facility Name (If not institutio		-			y, Town, or L kton	ocation of [Death			ounty of Dea	ath	
			Union Hospital 5. Social Security Number	6. Sex		s. last birthday			If Under 24	Hrs.	3. Date of Birti	h	cil	rthplace (State	or Foreign
	Funeral Director		179-22-0142	1 □ M 2 🖺 F		4 Yrs.	Months	Days	Hours	Min.	(Month, Da) 5-4-193	y, Year)	0	country)	
	<u> </u>		Usuel Residence of Decedent)-4-13.	DU	COc	tesvil	
	arylar ahow	_	10a. State 10b. County	1	10c.	City, Town or L	ocation							10d. Inside (
	Ba-1:	Director	MD Ceci	.1	N	orth Ea									2 X No
	with ti	直	10e. Street and Number 550 Hances Poi	~# D4				Code					n of What C	ountry?	
	death with the Maryland ms 23e or 28a-f show r nust be notified at	Funeral	11. Marital Status		ecedent Ever in	11 9 13		20901	nanio Origin	n2 (Spec	ify Yas or No	USA	Pace - Am	erican Indian,	
	fler d	F	1 Never Married 2 Mai	Armed	Forces?	0.0.			Mexican, F	Puerto R	ify Yes or No- ican, etc.)		Black, Wh	ite, etc.	
3	urs a	þ	3 Widowed 4 Divorced	If Yes,			1 🗆 Yes	2€ No	Specify:			S	pecity: Wh	ite	
3-003b	be filed within 72 hours after death with the Marylan Hygiene. It Hygiene. It han "natural", or items 23e or 28e-1 show event, the Medical Examiner must be notified at	Completed	15. Deceder	nt's Education	d)	16a. Dece	edent's Us	ual Occupati	on nna most o	of working	7	16b. Kind	of Busines	s/Industry	
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ᅙ	Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ford Ce	-		1	25 1	2004	0		17	
Бапптог	7 5 5 5		21. Signature of Fuperal Service		111			and Address	of Facility	-25–2			ord, E		
ñ	Depar Impo		Tallhu	(HA	//w/)vfor	d, PA	1936	dwar	d L. C	Collin	ns Fur	eral Ho	ome Ind
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that	at caused the de									Approxima Interval Be	ite
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	/Medical		resulting in death)	- a.	to (or as a cons	equence of):		-		-				0713	
	Examiner		Sequentially list conditions.	b	NEUHO	NIA								DAYS	
)	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	to (or as a cons									240	
`_	xecut and Il-tran	Examiner	that initiated events resulting in death) Last		to (or as a cons		יכדוטו	e pul	MON A	HLY	DISEA	56		YEARS	
09/8	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	aiE			·	. ,									
/ 89	ficate g phys	edicai		d											
ROX	leath certific attending p I for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnapt		outcome of pred							23	d. Date of de	elivery	
מ	death e atte	icia	in the past 12 moeths? 1 ☐ Yes 2 ☐ No	4∐Pre	e birth 2 □Fi egnant at time o		Other (pregnancy specify)					Month	Day	Year
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=		Con	0 stew or thr	stes							1 Yes	rmed? 2 No	death? 1 ☐ Ye	s 2 No	
Vital Records,	rsician: The law s certificate has l lirector, page 2 s	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
0	Phys this al dir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death			☐ ER/Outpatie		OCA Other	4 🗆 Nursi		e 5 Resid			ecify)	
בס	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pend	ing (M	ite of Injury Ionth, Day Year,	Injury	M	Work?	s 2∐No		id. Describe i	iow inquiry	500011100		
Division of	Atten deat ctor: y the	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ace of Injury - A	t home, farm, st					3f. Location (S	Street and	Number or F	Rural Route Nui	nber,
2	after after Dire	erti	4 Homicide	bu	rilding, etc. (Spe	ecify)		,,			City or Ton	m, State)			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certify	ing Physicien: To	the best of my l	nowledge, dea	th occurre	d at the time	, date and p	place, ar	nd due to the	cause(s) a	nd manner a	is stated.	
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medice one)	I Exeminer: On the and m	e basis of exam anner stated.	ination and/or in	nvestigatio	on, in my opir	nion, death	occurred	d at the time,	date and p	lace, and du	e to the cause	s)
	To t To t	Σ	29b. Signature and title of certifi				2	9c. License						nth, Day, Year)	
			1 4	H D				0004	וודו			Septe	Mber	23, 2001	t
	0		30. Name and address of person	who completed c	ause of death (I	tem 23a) (Type	, Print)	# 2 EI	letons	u.A	REF CHEN IN	الم	921		
		to	31. Date filed (Month, Day, Year	304-506 1 7 2004 32	2. Popistrar's Sid	gnature	arre .			7-11	- (- FP- D				
	Sta Regist		SEP 2	7 2004	Klasue	J. A	port								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 DI 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** Ruth Helen Kimmerling 10:00 A September 22, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Aug. 3, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 XX 95 Director 577-50-7779 Indiana Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral, or itams 23a or 28a-f show Examiner mant be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14711 Seneca Road 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify: White þ Yes Give Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Amelia Wigmore William Hamilton 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kathryn Recknor / Daughter 14711 Seneca Rd. Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ita eny Injury or ot Sept. 24, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Ser 19501 Catoctin Mtn. Hwy. Frederick, MD 21701 Enter the disease, or k, or heart failure. List Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** Acute Pancreatitis 24 hrs. /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inflated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 🔯 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Mainpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: after death Director: filled in by within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Jude/Alexander, M.D. 9901 Medical Center Drive; Rockville, MD 20850 31. Date filed Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nus

29d. Date signed (Month, Day, Year)

September 22, 2004

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 58681

				partment of Health and Me ertificate of Death	ental Hygie Reg.	2001 21050
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Anna Lucrezia Kerry	S	Month eptember	^{Day} 20, 2004 1955 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			11431 Georgetown Drive	Potomac		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 550-68-2997 1	Months Days Hours Min.	Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	J	Tuly 15,	1930 Italy"
	land ow		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Man 1-1 sh	ţoţ	Maryland Montgomery Potomac			1 ☑ Yes 2 ☐ No
	h the	lrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th will	a	11431 Georgetown Drive	20854	Un	ited States
	tems	by Funeral Director	Armed Forces?	B. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	Y.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 3 🛣 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
8	hour	edb		edent's Usual Occupation	166	NILLE NITLE
15	n n	Completed	(Specify only highest grade completed) (Gir	re kind of work done during most of working . DO NOT use retired)	'	. Island of Business/muustry
212	yiene r the	E	Elementary/Secondary (0-12) College (1-4or 5+) Self	Employed	F	ashion Design
פ	othe othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (i		
<u>Ja</u>	Ments Ments arked	Tof	Giuseppe Taticchi	Maria Ful	via Chie:	ricati
Maryland 21215-0036	and and is ma		D . 17 / 6	iling Address (Street and Number or Rural F		
≥	and lealth m 27 her tr			1 Morning Gate Drive		
Baltimore,	Lof H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Discomptony of Competency of Montal	position (Name of ematory or other place) Septem Septem 26	nber	. Location - City or Town, State
Ħ	t. Pa rtmen rtent:		Cremato	rium, Inc. 20, 20		thesda, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or items 23a or 28a-1 show any injury or gither fraumatic event, the Madreal Examiner must be notified at once.		21. Signature of Funeral Service Licensee MQ0689	ockville, Inc. 300 V Rockville, Maryla	Vest Moni and 2085	mphrey Funeral Home/ tgomery Avenue, 0-2805
			23a. Fart1. Enter the disease, or complications that caused that death. Do not e spock, at heart sailure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute Respirato			Onset and Death
Н	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
Н	Examine:	_	Sequentially list conditions, Term, leading to ammodiate b. Emphysema Due to (or as a consequence of):			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
	al-trai	xar	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d			
9	ifficat g phy as the	edic				
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy		23d. Date of delivery
B	deat	sicia	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month Day Year
<u>о</u> .	at the de I by the a stached	h	9 Unknown			
Ś	res that igned to be det	by	Part II. Other significant conditions contributing to death but not resulting in the Arteriosclerotic Cardiovascular Disc			co use contribute to the cause of death?
Records,	w require been si should t	Completed	Arterioscierotic Cardiovascular Dis	ease	1 🔀 Yes	2 No 3 Probably 4 Unknown
ec	e law has b	npie			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
					performed 1 ☐ Yes 2 🔯	
Vital	Attending Physician: The r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C		
ō	Phys r this ral di	To.	1 ☑ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ent 3 DOA 4 Nursing Home	5 Residence d. Describe how in	6 □Other (Specify)
o	ding th. : After funer	tion	1 🛣 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation			nary coouring
Division of	I or Attendi after death. Director: A I in by the fi	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	street, factory, office 28f	. Location (Street	and Number or Rural Route Number,
á	P di di	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ate)
	To the Hospital or within 24 hours after To the Funerel Discompletely filled in		29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	due to the cause	e(s) and manner as stated.
	the the the mplet	Medical	and canner stated. 29b. Signature and Aith of perimer	29c. License number		
	Z W Z		THE THE METERS OF THE METERS O			Date signed (Month, Day, Year)
	15		- MKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKKK	D21531	Se	ptember 21, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type			1 000FC 0706
	Sta	te	G. Peter Pushkas, M.D., 11510 01d Ge 31. Date filed (Month, Day, Year) 32. Registrar's Signature		viile, W	aryland 20852-2736
	Registr		SEP 2 4 2004 Server B	Sporks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year CHRISTOPHER M. LEE SR. SEPTEMBER 23 2004 12:12AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10480 CORDOVA RD. EASTON TALBOT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex X□M 2□F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Yrs. 70 **Director** 149-24-8666 NOV 14 NEW JERSEY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or itams 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10480 CORDOVA RD 21601 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married WHITE 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR EXCAVATION 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any lipity or other traumatic event 2008. 18, Mother's Name (First, Middle, Maiden Sumame) ALLISON W. LEE JESSAMINE MIDDLETON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA G. LEE/WIFE 10480 CORDOVA RD., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 □Donation 5 □ Other (Specify) GREENMOUNT CEMETERY 9-28-2004 HILLSBORO, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 NOHN R. MERCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9mos Myclamonocytic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? res 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA L)S 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital After this funeral of Certification: death.

Baltimore, Maryland 21215-0036

within 24 hours after deat To the Funeral Director: completely filled in by the

State

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 🗌 Suicide

29a, Certifier

4 | Homicide

6 Could not be determined

MARY DESHIELDS M.D. 509 IDLEWILD AVE EASTON, MD 21601

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

		1	- For Amend Item 25	State of Maryla per Hosp.,	nd / Depa 3836,<u>&</u>9/	rtment of H	ealth and M Death		iene _{eg. No} 20	04	31952
1		7	Decedent's Name (First, Middle, Last)		-			2. Date of Deat Month	h Day	Year/	3. Time of Death
	Physicia	20	JOSEPHIN	E LAN	DRY			10	5	04	0020 4
	/Medic Examin	1.6	4a. Fecility Name (If not institution, give s	treet and number)	11	4b. City, Town, or	Location of Death		4c. County	of Death	,
	LAGIIIII	٠.	ANWARX COUNT	LY GENERAL T	NOSO. FOC	Cohur	mbiA		W/00	UNR	<i>d</i>
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	Coul	
	Director		454-03-0040	M 2 XF 89	Yrs.			Nov 1 1	914	Loui	.sianna
	D >		Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Loc	cation					10d. Inside City Limits
	anyla shov	2	Md Howard		Columbia						1 ☐ Yes 2 No
	Ne M	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show r must be redified at			t 346A		21044			USA		
	s 23	eral		12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Rac		can Indian,
	be filed within 72 hours after death with the Marylan at Hygiene. All Hygiene. Activities "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show are not. In a Marilcal Evaning must be indiffed at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Yes, specify Cuba □ Yes 2☐No	n, Mexican, Puerto Specify:	Rican, etc.)	Specil	ck, White, _{fy:} Whi	
ş	2 hou		15. Decedent's Edu	cation	16a. Deced	ent's Usual Occup	ation during most of work	ing	16b. Kind of B	lusiness/Ir	ndustry
9500-C12	7 nin 7. n ni	Completed	(Specify only highest grad	College (1-4or 5+)	life. L	OO NOT use retired	i)	""9	dama at		
7	filed within Hygiene. sther than "ent, tra Me	E O	Elomoniary, 30000 readily (5 12)	2.	ROM	emaker			domest		
פ	be file stal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumai	me)	
iand	Mental Merked o arked o	2	John Benjamin Mart	in			Velma I				
Mary	s 1 and 2 should be of Health and Mental item 27 is marked of other traumatic ev		19a. Informant's Name/Relationship (T)				and Number or Rur				
	1 and 2 Health Iem 27 I		Bryan T. Landry Jr				cett Rd.,				
aitimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		sition (Name of natory or other place y Cremati	ion 10-08	Date -04, S	20c. Location Sykesvi	,	
Baiti	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licens Page Margh	Herbert		.O. Box	ss of Facility Ha 195 Sykes	ight Fur ville, M			Chapel
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the d							Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of	1/601/2					1.00
п	Examiner			. Vino	ep fre	15/00/					7EARS
	District Control	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):						/
	ate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Ó	exectan an an rial-tr		resulting in death) Last	Due to (or as a con-	sequence of):						
8760,	ysicie ysicie	cal		d							
9	tifical g ph as th	ed									
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnanc	Y			ate of deli-	very Day Year
	that the death cer ed by the attendir detached for use	icla	in the past 12 months?	4☐Pregnant at time		Other (specify)	<u> </u>		10	IOI III	Day . our
P.0	t the deby the tached	hys	9 Unknown					an- Dida		-1-1510-10	the equipp of death?
Vital Records, F	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	entributing to death but not	resulting in the u	inderlying cause gi	ven in Part I.		obacco use cor ⁄es 2□No		the cause of death?
00	w rec	Completed	1					24a. Was		. Were aut	topsy findings available ompletion of gadse of
Re	0 4 0	E						perfo	rmed?	death?	2 NO
a	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Dea		P		
5	Physician: r this certific ral director,	00	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Ot	ner: 4 🗌 Nursing H	ome 5 Resid	dence 6 🗆 O	ther (Spec	cify)
on of	ding Phys h. After this funeral di	tlon: T	27. Mann of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Wo	ry at rk?] Yes 2 □ No	28d. Describe I	now injury occu	urred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined		At home, farm, st	reet, factory, office		28f. Location (S City or Tox		nber or Ru	ral Route Number,
	e Hospital 5 24 hours a e Funeral l letely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea nination and/or in	th occurred at the to	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	nanner as a, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	13	•	29c. Licen	se number		29d. Date sign	ned (Month	n, Day, Year)
	To To		Van'h	. ()	DA	2. DOC	27718	>	10	11/1	04
			30. Name and address of person who	complete cause of death	11 m 23a) (Tune	. Print)			10	1010	
			30. Name and address of person with	BIVITS S A	10. 55	75 Cod	Lane	Colu	mbia,	MD.	21044
	Si Regis	tate trar	31. Date filed (Month, Day, Year) OCT 0 8 2004	32. Registrar's S	Signature	parks	2016	,	()	(
-	neuis	11(2)		1"T "	/	7					

		-	For State Registrar	State of Maryland	Department of H			ene g. No.2 () ()	4 31953
	hysici /Medic		1. Decedent's Name (First, Middle, Las Shirkey Awa	LAYER			2. Date of Death Month SEPTEMBE	Day \	3. Time of Death 2004 04 AM
3.	Examin		4a. Facility Name (If not institution, give	NITY HOSPITAL	- HAGE	r Location of Death 2570しん	1	4c. County of	Death /
	uneral rector	¢	5. Social Security Number 6. Se L/H-H2-//62 Usual Residence of Decedent	7. Age (In yrs. last	Yrs. If Under Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Office 17,	Year) 1	9 Birthplace (State or Foreign Country) FRED - 100
Maryland	-f show live at		10a. State 10b. County M	1 11-	own or Location GERS TOWN	<i>i</i>			10d. Inside City Limits 1 ☑Yes 2 ☐ No
h with the	3a or 28a si ke nuli	Funeral Director	10e. Street and Number 501 Lunalhave	J DR. STE. 5	10f. Zip Code	t2 -	10	g. Citizen of Wh	
:1215-0036 within 72 hours after death with the Maryland ene.	Important: If Itam 27 is marked other then "natural", or items 23a or 28a-1 show any Injury or other traumatic event, Its Medical Examiner most be notified at once.	þ	11. Marital States 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race	American Indian, White, etc.
21215-0036 od within 72 hours af giene.	then "natu ne Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired MANAGEA	during most of work	ing 1	6b. Kind of Busi	,
Maryland 212 to 2 should be filed with the and Mental Hygiene.	rkad othar tic evant, I	To Be Co	17. Father's Name (First, Middle, Last) DANICL CALLE	cu	- Totalier	18. Mother's Name			<u> </u>
e, Maryla 1 and 2 should I Health and Meni	n 27 is ma ar trauma		19a. Informant's Name/Relationship (7		19b. Mailing Address (Street)		474		tate, Zip Code)
Baltimore, permit. Pages 1 a Department of Hea	Important: If Itam any Injury or otha once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	e of Disposition (Name of etery, crematory or other place of Lawy Cem	ce)			ity or Town, State PORT UNERAL HEME
Baltim permit. Pag Department	Import any Inj once.		21. Signature of Funeral Service Liben	lins	MOW. Sou	Th ST. F	Ato Me).	UNERAL HOME
/M	sician edical miner		23a. Part1. Ents the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequen	corellal	g, such as cardiac o	or respiratory arres	it,	Approximate Interval Between Onset and Death
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K 68760, ertificate be ex	ling physic e as the b	Medical	IF FEMALE:	d					4.00
. 0	the	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 100 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy	,		23d. Date Monti	
□ tal	s been signed by should be detac		Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause give	en in Part I.		_	oute to the cause of death?
	G (2)	Completed	1 Adr	controlled	2 Leabeld	s Melli	24a. Was an autopsy perform	ed2 pri	ere autopsy findings available or to completion of cause of ath?
	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	/Outpatient 3□ DOA Othe	26. Place of Death	n (Check only one		(Specify)
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Division of To the Hospital or Attanding Phy within 24 hours after death.	To tha Funaral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined				28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
he Hospit in 24 hour	ha Funare pletely fille	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of my knowle- iner: On the basis of examination and manner stated.	dge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manr e and place, an	ner as stated. d due to the cause(s)
Tot	Tot	Σ	29b. Signature and title of certifier	ble	29c. Licenson		296	1. Date signed ($9/22/$	Month, Day, Year)
	5		30. Name and address of person who a	completed cause of death (Item 23	(Type, Print) Mell St-	Hagers	town, I	10217	20
%	Sta Registi	_	31. Date filed (Month, Day, Year) SEP 2 7	32. Registrar's Signature	& Apo	rks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 05 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** рм 2004 1:10 September 22, Frederick Joseph Manning /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockyille
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)
Jan. 27, 1944 Montgomery

9. Birthplace (State or Foreign
Country) Montgomery Hospice-Casey House
5. Social Security Number
6. Sex
7. Age (In yrs. last birthday) **Funeral** Months 1 🖾 M 2 🗆 F 60 Yrs. Massachusetts Director 032-32-2090 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other traumatic event, the Modical Examinat roust be contilled at 1 ☐ Yes 2 X No Director Burtonsville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s nor any injury or other traumatic excess USA 20866 15650 Santini Road Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1969-94 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify: Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Complet Elementary/Secondary (0-12) College (1-4or 5+) Psychologist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Marie Pettit Joseph Francis Manning 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15650 Santini Road, Burtonsville, MD 20866 Ellen Marie Manning/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State October 5, * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Arlington, Virginia Cemetery 22. Name and Address of Facility of Juneral Service Licens 21. Signatur Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd, W, Silver Spring, Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final Pnysician disease or condition resulting in death) Advanced Renal Coll Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events coulding in death). Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 TYes 21€ No Small Bowel Obstruction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 X No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 FlOther (Specify)Hospice 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

attending physician and for use as the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by the a should be been has page 2 To the Hospital or Attending Physician: director, this within 24 hours after death.

To the Funaral Diractor: After th completely filled in by the funeral

the Maryland

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 20855 Rockville, 6001 Muncaster Mill Road, Charles Harrison, M.D.

31. Date filed (Month, Day, Year) State

SEP 24 2004

32. Registrar's Signature

Registrar

			For State Registrar	State of	Maryland /		artment rtificate			ınd Me		ene	004	31955
	Dhuniai		1. Decedent's Name (First, Middle, L	ast)	V					2.	Date of Death	Day	Year	3. Time of Death
	Physici /Medic	al -	Mildred	McCe1							ept.22	200)4	1:45 p M
~	Examin	er	4a. Facility Name (If not institution, g	ive street and numb ton Park	ber)		, ,		Location o	f Death			ounty of Deatl	
	Funeral				. Age (In yrs. last bi	irthday)	If Under	1 Year	If Under 2	24 Hrs 8.	Date of Birth		9 Birti	nolace (State or Foreign
	Director		488.26.9999	1 □ M 2 □X	93	Yrs.	Months	Days	Hours	Min. A	pril Days	3 ^{year)} 19	11 K&	Tucky
	pu s		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	vn or Lo	cation						-	10d. Inside City Limits
	daryle f sho	ō	MD Montgo	mery	Rock									1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number				10f. Zip	Code			10	g. Citize	n of What Co	untry?
	h with	al D	11008 Wickshir	e Way				208.	52			U.	S.A.	
	ams erre	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S. es?	13.	Was Deced	ent of Hi	spanic Orig	in? (Specif , Puerto Ric	y Yes or No- can, etc.)	14.	Race - Ame	
36	s afte	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	2[XNo	Specify:			Sį	oecify:	White
9	d within 72 hours after death with tha Maryland jene. Ir than "natural", or Itams 23s or 28s-f show The Medical Examinatingst be multified at		15. Decedent's	Education		. Dece	dent's Usua	l Occupa	ation			6b. Kind	of Business/I	ndustry
215	within 72 ene. than "na	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4	4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)								
2	a filed wil I Hygien other th	Con	4				Homen	nake:		d- N //		4-74- 0	Own Ho	me
Maryland 21215-0036	I ba fil ntal H ed ott	Be	17. Father's Name (First, Middle, La John F1c	-					18. Motne		First, Middle, N ginia			
Ϋ́	should Ind Men	ဥ	19a. Informant's Name/Relationship		19	b. Mailír	ng Address	(Street a	and Numbe		Route Number,			lip Code)
Ma	and 2 sealth ar m 27 is ner trau		William Penderga											
ore,	of Hei		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3	□ Bomoval from St	20b. Place o	of Dispo	sition (Nam natory or ot	ne of ther place	ө)	Date	9 2	oc. Loca	tion - City or	Town, State
Ĕ	Pages ment of lent: If its ury or o		*4 □ Donation 5 □ Other (Spec	cify)	Mt. Co					_	27,2004			•
Baltimore,	parmit. Pages 1 and 2 should ba filed Department of Health and Mental Hyg Importent: If item 27 Is marked othe any injury or other traumatic event,		21. Signature of Funeral Arvice Lice	m B	m						eph Gaw e NW Wa			
Γ			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cally one cause on ea	used the death. Do ch line.	not ent	er the mode	of dying	g, such as	cardiac or r	espiratory arre	st,		Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cano	er of the	e Es	ophag	us_						Onset and Death months
	/Medical Examiner		resulting in dealin)	Due to (o	r as a consequence	of):								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (o	r as a consequence	of):								
	cuted nd ransit	Examiner	that initiated events	с										
ó,	ba exacuted siclan and burial-transit		resulting in death) Last		r as a consequence	of):								
8760	cate b	dlca		d										
9 x	death certificate ba exacuted e attending physiclan and td for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnancy							230	d. Date of deli	verv
Box	death e atter d for u	clar	in the past 12 months?	4☐Pregna	th 2 □ Fetal deat nt at time of death]Ectopic pre] Other <i>(sp</i> e						Month	Day Year
P.0	at the de by the tachad	hys	9 Unknown	9□ Unknov	wn							į		
Vital Records, F	Tha law requires that the Ite has been signed by th vage 2 should be detacha	þ	Part II. Other significant conditions	s contributing to dea	ath but not resulting	in the u	nderlying ca	ause give	en in Part I.	_		acco use s 2□1		the cause of death? bably 4 Whitnown
ooa	law reas becase becase becase becase becase becase becase becase because and a second becase because and a second because because and a second because a second	Completed		<u> </u>							24a. Was an	, 2	24b. Were au	topsy findings available completion of cause of
œ =		Com									perform	ned?	death?	2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only one			A 1
of	Phys this ral di	. To	1 Yes 2 No 27. Manner of Death	1 □ In 28a. Date of (Month		Time o	nt 3□ DO	Bc. Injury	at		5 Reside d. Describe ho			hify) Assisted Living
ion	Attending For death. sector: After by the funer	atior	27. Manner of Death 14. Natural 5 ☐ Pending 2 ☐ Accident investigat		, Day Year)	Injury	М	Work	(? Yes 2 □ N	No				
Division	afte Dir	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	286. Place	of Injury - At home, f g, etc. <i>(Specify)</i>	iarm, str	eet, factory	, office		28f	Location (Str City or Town		Number or Ru	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the teminer: On the base	pest of my knowledg	ge, deat nd/or in	h occurred a vestigation,	at the tim	e, date and pinion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) ar	nd manner as ace, and due	stated. to the cause(s)
	o the ithin 2 o tha omple	Mec	29b. Signature and title of certifier	andmanne	er stateu.		29c	. License	number		29	d. Date s	signed (Month	o, Day, Year)
			1 South			m	in in	0.	333	57		Sept.	. 23, 2	2004
	V		30. Name and address of person who Johnathan	no completed cause Musher, M	of death (Item 23a)	Type,	Print)	in A	venue	Chev	y Chas	e, MI	20818	3
	Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signature	19	10	n. W.	./					
	Regist	State M. Market												

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PAUL MIRAKIAN, JR. September 18 2004 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 11813 Renick Lane Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs. 1929 Richmond, Director 229.40.3534 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show The Medical Examiner must be nutified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 11813 Renick Lane 20904 U.S.A. "naturel", or Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1953 1 ⊠Yes 2 □ No If Yes, Give to Year or Dates: 1967 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1967 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene Important: If itam 27 is marked othar than "ne any injury or other traumatic event, the Media once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Industrial Engineer 4 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mirakian Paul Elizabeth Yazegian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty C. Mirakian/Wife 11813 Renick Lane, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 9/22/04 Rockville, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HINES-RINALDI FÜNERAL HOME INC 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATI Priysician 34RS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy signed by the atte Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 Yes 2 No funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F s after death. Il Diractor: After id in by the funera After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide within 24 hours after de To tha Funaral Diractor completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospitai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number MUD D0061083 September 22, 2004 30. Name and address of person into completed cause of death (Item 23a) (Type, Print) Center Dr, #300, Rockville, MD 20850 Thambi, MD9707 Medical Paul M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DAMERAND SEP 2 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year September 21, 2004 11:37 M MAMIE INEZ ALICE JOHNSON COLEMAN MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deeth **Examiner** If Under 1 Year If Under 24 Hrs. Fort WAShing Tool Hospital Cecres 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours 577-48-4581 85 Director MARYLAND APRIL 18, 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f ahow the Medical Enaminer must be notified at 1 XYes 2 ☐ No Directo MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 12318 LIVINGSTON ROAD 20744 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: BLACK 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 8TH GRADE (0-12) College (1-4or 5+) FOOD SERVICE WORKER FEDERAL GOVERNMENT Ith and Mental Hygie 27 is marked other r traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) JAMES JOHNSON LUCY FORD RANSOME JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAYVON MILLER / HUSBAND 12318 LIVINGSION ROAD, FORT WASHINGTON, MARYLAND 20744 20a. Method of Disposition
1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GRACE UNITIED METH. CH. CEM. 9/27/2004 * 4 ☐ Donation 5 ☐ Other (Specify) FORT WASHINGTON, MARYLAND 21. Seture of Funeral Service Liben MO0583 THORNION FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Arterioscherotic **Physician** He pertersise Heart disease or condition resulting in death) /Medical Examiner Securitary list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 1 ☐ Yes 2 ☐ No 2 No : After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manna T Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A I Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide perili 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Londo HOUS591 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hos 300 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP % 4 2004 Registrar A STORES

	Physicia	an	- State Registrar 1. Decedent's Name (First, Middle, Last) Robert Alfred P		rtificate of Death		Day Year	3. Time of Death
Y A	/Medic Examin	er	44 Facility Name (III not institution give si MALCOLM GROW MEDIC		4b. City, Town, or Location of Dea CAMP SPRINGS If Under 1 Year If Under 24 Hrs	th P	tc. County of Death	RGES
	Funeral Director		5. Social Security Number 223-44-3416 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last birthday) 68 Yrs.	Months Days Hours Min			
	he Marylan 28a-f show	ector	10a. State 10b. County Maryland Prince Ge 10e. Street and Number	orge's Ac	ccokeek	100.0	Citizen of What Cou	10d. Inside City Limits 1 Tyes 1 No
	23a or	al Dir	16724 Huron Street		20607	109.	USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event har must be notified at once.	by Fur	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No	Was Decedent of Hispanic Origin? (! If Yes, specify Cuban, Mexican, Puel 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur ina Medisal	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Warrant Officer	orking	Kind of Business/Ir	•
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re, Mar	Health and the tem 27 is mother traum		20a. Method of Disposition	eton - Wife 16724		cokeek, MD		-
altimo	pernit. Pages Department of Important: If I any injury or once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Huntt Cre			ldorf, MD	
	€ 34 ,			ations that caused the death. Do not ent e cause on each line.	. 0. Box 156, Wall er the mode of dying, such as cardia	dorf, MD 20 c or respiratory arrest,)604	Approximate Interval Between Onset and Death 2 DAYS
	Physician /Medical Examiner		disease or condition resulting in death)	SEPSIS Due to (or as a consequence of): SMALL CELL LUNG C	ANCER			6 MONTES
8760,	icate be executed physicien and s the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
.O. Box 68	The law requires thet the death certifical tile has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
D	w requires thet been signed b should be deta	by	Part II. Other significant conditions conditions CORONARY ARTERY DIS		nderlying cause given in Part I.	23e. Did tobacc	o use contribute to to 2 □ No 3 🛣 Pro	the cause of death?
al Records,		Completed				24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{L} \)	prior to co	opsy findings available impletion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes No	ospital: 1 Anpatient 2 ER/Outpatier	Other	ath (Check only one) Home 5 ☐ Residence	6 ☐Other (Speci	(v)
Division of	utending Physideath. ctor: After this y the funeral di	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred	
Divis	or A		4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	
		edical	(Check only one) Medical Exemin	ician: To the best of my knowledge, deatler: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occ	urred at the time, date a	nd place, and due t	o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	many)	29c. License number		Date signed (Month,	
<	12 11/11		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type,	IN 01054304A Print) 89 MDG/1050 W		TEMBER 22 ROAD	, ZUV4

	an	Decedent's Name (First, Middle, L.		Kenneth Porzi						2. Date of Death Month Day Sep 21, 200			3. Time of 0224	Death
/Medic		4a. Fecility Name (If not institution, gr		-			Town, or	Location of	of Death		4c. Count	-		
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Funeral Director		5. Social Security Number 6. 140-22-8806	Sex 1⊠M 2□F		last birthday) 75 Yrs.	If Under 1 Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jun	th y, Year) 4, 1929	Cou	plece (State or intry) New Jerse	
≥ -3	1	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation							10d. Inside Cit	v Lim
s a ba	ō	,	ccomack		hinco	1	UC						1 Yes	
28a-	Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cou	intry?	
23a o		8259 Sea Shell Drive						233	336			U.S	S.A.	
SE SE	Funeral	11. Marital Status	12. Was Deceder Armed Force			Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		ce - Amer	ican Indian,	
I, or it	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 (X) Yes 2 [If Yes, Give Year or Date:			1 🗆 Yes 2		Specify:		,	Speci		White	
atura	ted	15. Decedent's I	Education		16a. Dece	dent's Usual					16b, Kind of B	Business/li	ndustry	
en "ne Made	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4c	or 5+)		kind of work DO NOT use	e retired)		t of work	ing	Self			
giene er th	Соп	12		,				Sales						
Department of Health and Mental Hygiene. Important; or items 23e or 28e-f show important: if item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	To Be (17. Father's Name (First, Middle, Las Add	st) olph Porzl					18. Mothe	r's Name		Maiden Sumai Senta Kogl			
ealth and Men n 27 is marked ser traumatic		19a. Informant's Name/Relationship Jean Porzi Wife	(Type, Print)			_				al Route Numbe	er, City or Town	, State, Zi	p Code)	
item item othe		20a. Method of Disposition		1 0	Place of Dispo emetery, cre	osition (Nam	ne of ther place	9)	(Date	20c. Location	- City or T	own, State	
nent of h int: if ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		ite		annock C		. 1) .	09/22/04		Exmo	re, VA	
Departri importe any inju		21. Signature of Funeral Service Lice	ensee		2:	2. Name and			•					
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aminer		resulting in death)	Due to (or :	as a consequ	uence of):	OLITIS	<u> </u>						Onset and D	- Gal
	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. C. Due to (or contract)	as a consequence as a c	uence of):	04719	S						Onset and U	Gall
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			1 - For State of Maryla		artment of F			iene	31961
			Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	_	MERLIN HARDY PORTER-BOR	RDEN			Septembe	r 16, 2004	4 5:00 P M
	Examin		4a. Facility Name (If not institution, give street and number)			or Location of De	ath	4c. County of Dea	
			Frederick Memorial Hospital		Frederi	CK ☐ If Under 24 Hi	10 D	Freder	
	Funeral Director		573-54-2766 ¹ M 2□F	rs. last birthday) 64 Yrs.	Months Days	Hours Mi		Year) 9. Bi 1939 Ca.	nthplece (State or Foreign ountry) Lifornia
	D		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	laryia eho	ក							1 □ Yes 2 No
	28e-1	ect	Maryland Frederick Li	ibertyto	10f. Zip Code		10	og. Citizen of What C	ountry?
	death with the Maryland ms 23a or 28e-f ehow cruss be notified at	Funeral Director	9129 Liberty Village Way		217	91		U.S.A	١.
	death ms 2;	era	11 Marital Status 12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am	
٥	or ite		1 Never Married 2 Married 1 Yes 2 No If Yes, Sive	1	ir res, specify Cub 1 ☐ Yes 2 🛣 No		ento Hican, etc.)	Black, Wh	
5-0036	72 hours after natural', or ite	d by	3 Widowed 4 Divorced Year or Dates:					WI	nite
ភ	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	vorking 1	6b. Kind of Business	s/Industry
7	within ene. then	du	Elementary/Secondary (0-12) College (1-4or 5+)		ivil Eng:	•	1	Federal Go	wernment
2	e filed with If Hygiene. other ther vent, the N	e Co	17. Father's Name (First, Middle, Last)		TVII DIIG.	1	lame (First, Middle, M		VCIIIIICITC
ryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Heath and Mental Hygene. Heath and Mental Hygene it from 27 is marked other then "natural, or items 23a or 28e-1 show other traumatic event, the Medical Examines must be notified at	To Be	George Porter			Nellie	Hardy		
<u></u>	should be and Mental a marked umatic ev	Ē	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or i	Rural Route Number,	City or Town, State,	Zip Code)
<u>8</u>	and 2 seath arm 27 is	1	Catherine Porter-Borden (Wife)	1011	Chery1's	Court,	Frederick	, MD 21703	
ē,	item of Hei	1			natory or other pla			Oc. Location - City o	Town, Slale
Ĕ	Page nent c ant: If		*4 Donation 5 Other (Specify)	mithsbu	rg Cremat	tory 9/1	.7/04 Sn	nithsburg,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signatur of Furieral Service Licensee				SON FUNER	•	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
ž.	Physician		A	-lo atta	- ¿ Ca	Links	and To	50312	Onset and Death
è	/Medical		resulting in dealh) Due to (or as a cons		0 00,77			6-0-	
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	pe şis	Examiner	if any, leading to immediate Due to (or as a conscause. Enter Underlying Cause (Disease or injury	sequence or):					
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20	ficate g phy.	edlo	U.						
ŏ	death certificate e attending phys id for use as the	n/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F		Ectopic pregnanc	.,		23d. Date of de	
n	the deati y the atte ached for	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)		· · · · · · · · · · · · · · · · · · ·	Month	Day Year
л О	uires that the de signed by the a ld be detached f		Part II. Other significant conditions contributing to death but not	resulting in the u	nderiving cause giv	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
g,	aw requires that as been signed b 2 should be deta	d by	Atrial Fibrilation	,	, , ,		1 ☐ Ye	s 2 No 3 P	robably 4 Dunknown
cords	req	ete					24a. Was an	24b. Were a	utopsy findings available
Ĕ	9 4 8	Completed					- autopsy perform	prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medical			26 Place of D	1 ☐ Yes 2	☑No 1□Ye	s 2 No
	Physician: r this certifica ral director, p	0 0	examiner?	ER/Outpatier	nt 3 DOA Ott	200	Home 5 ☐ Resider		ecify)
on of	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	tlon: T	27. Manner of Death 1	28b. Time of Injury	Wo		28d. Describe hor		
DIVISION	or Attenter ter deat irector:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	it home, farm, str ecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	lural Route Number,
2	pitei o ours al arei D	Ce	200 Codifier 1 Codificing Physicians To the heart of	knowledge de:	h convered at the st	ma data and at-	co. and due to the	usals) and m	e ctated
	Hosp 24 ho Fune etely f	edical	29a. Certifier 1 Critifying Physician: To the best of my in Check only one) 2 Medical Exeminer: On the basis of exam and manner stated.						
	To the within Fo the	Me	29b. Signature and title of certifier	0	29c. Licens	se number		d. Date signed (Mon	
			(Malu +	1	'D35	5164	S	ptember	17,2004
	10	- 1	30. Name and address of person who completed cause if death (I	Item 23a) (Type,	Print)				
	10				t, Freder	ick, Ma	ryland 217	01	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 4 2004		los				
- 3	, incgiou	41	DET 64 /1114 12000	6)	ana	11. 1			

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year September 19 2004 **Physician** 3:10 P M Shirley C. Powell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7408 Epping Avenue Ft. Washington Prince George's 8. Date of Birth (Month, Day, Year) Mar. 19, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 DyF Months Days Hours 577-54-9993 *"*1′939 65 Director Wash. Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b County 10a State show 1 XYes 2 No Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 7408 Epping Avenue or Itams 23a 20744 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ital 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Black Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Postal Service Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Blacknell Robert Thompson, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila B. Powell - Daughter 7408 Epping Ave., Ft. Washington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 9/25/2004 Landover, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furnal Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Supses Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusease or injury that initiated events Examine requires that the death certificate be executed attending physician and for use as the burial-transit englierat resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Disbetes mellete Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed 2□ No certificate 2 No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XVatural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and his of certifier 29d. Date signed (Month, Day, Year) 026352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAIR 9131 Per swall 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

		4	For State Registrar	State	of Marylar		irtment of tificate of				giene Reg. No.	04	31964	
			Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic		Madeline Franc	ces Pisc	iotta					Septemb			6:30 am	
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town,	or Location	of Death		4c. Cou	nty of Death		
			Suburban Hosp	ital			Bethe	esda			Mor	ntgome	ry	
Т	Funeral			S. Sex	7. Age (In yrs.		If Under 1 Yea Months Day		r 24 Hrs. Min.	8. Date of Birt (Month, Day	h /, Year)	9. Birth	place (State or Foreign ntry)	
	Director		215-46-2407	1□M 2気F	8	36 Yrs.	Monard Suy			(Month, Day Aug. 11	, 1918		ington, DC	
	P _		Usual Residence of Decedent		10a Ci	to Town and a	-ation						10d. Inside City Limits	
	inylar show	_	10a. State 10b. County			ity, Town or Lo							1 □Yes 2X No	
	Ba-f	Sch	Maryland Montg	omery	S	ilver	-				10 000			
	音 2g 音	Directo	10e. Street and Number				10f. Zip Code				10g. Citizen		ntry?	
	be filed within 72 hours after death with the Marylan Hygiene. Hygiene Hygiene death Hygiene death with the marker in the marker in the Marylan Examena nutst be notified at event, the Marylan Examena nutst be notified at	ra	1006 Stirling				20901				USZ		and to dies	
	tams	Funeral	11. Marital Status	Armed I		J. S. 13. Y	Was Decedent of f Yes, specify Cu	Hispanic Oi Joan, Mexica	rigin? (Spe in, Puerto l	city Yes or No- Rican, etc.)		lace - Ameri Black, White,		
20	or i	by Fi	1 Never Married 2 Marrie	If Yes, C	s 2⊠No Give		1 ☐ Yes 2 %] N	o Specify	r:		Spe	city: Wh:	ite	
Š	urai'		3 € Widowed 4 Divorced	Year or	Dates:	16a Docor	dent's Usual Occ	unation			16b Kind of	Business/Ir	ndustry	
ប៉	"nat	Completed	15. Decedent's (Specify only highest	grade completed	d)	(Give	kind of work don DO NOT use reti	e durina mo:	st of worki	ng	100. 11110	Casillosail	idudity	
7	withir ane. than	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)	но	memaker				Own	Home		
N	Hygir ther int,	e Cc	17. Father's Name (First, Middle, La	ast)		110	memaner	18. Moth	ner's Name	(First, Middle,				
ă	o be	00	Gaspare Amato					Fra	nces	Geraci				
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itams 23a or 28a-f show marked other than "natural", or itams 23a or 28a-f show matte event, the Modical Exantana must be notified at	ပို	19a. Informant's Name/Relationshi	n (Type, Print)		19b. Mailir	ng Address (Stre				or, City or To	vn, State, Zi	p Code)	
≅ S	d 2 s th an trau	9					Stirli							
o,	1 an Heal em 2		Robert Pisciotta 20a. Method of Disposition	1/ 5011	20b.	Place of Disoc	sition (Name of			ber 25	20c. Location			
وّ	in it of		1 ☑ Burial 2 ☐ Cremation		m State Ga	te of	natory or other p Heaven	lace)	20 20	1	Silver	Spri	ng, Maryland	
	The state of the s		*4 □ Donation 5 □ Other (Special Service Li			Cemete		tress of Facil					ig, naryrana	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important: if Item 27 is marked eny Injuryer other traumatic events.		Lian	Mah	ler	5		ersity	Blvd	, W, Si	lver :		, MD 20901	
	184		23a. Pintl. Enter the disease, or c shock, or heart failure. List o	omplications tha	t caused the dea	th. Do not ent	er the mode of d	ying, such a	s cardiac c	r respiratory ar	rest.	2.00	Approximate Interval Between	
	Physician		23a. P. Int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ASPIRATION PNEMMONIA.											
	/Medical		resulting in death)	Due 1	to (or as a conse	quence of):								
И	Examiner		Conventially list conditions	h	EONO	TEST	IVÊ	HEA	127	FAIL	-uRt			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	to (or as a conse	quence of):	6.5		A					
	cuted nd ransi	Examiner	that initiated events	c	HIR	-IAL	FIBRILLATION.							
o	an ar		resulting in death) Last	Due t	to (or as a conse	quence of):	IC MELLITUS.							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	dicai		d	الم الر	15611		166	1111	/(> '				
9	ng ph	0	IF FEMALE:				-							
Вох	death certifica attending ph d for use as t	by Physician/M	23b. Was decedent pregnant		outcome of pregr e birth 2 Fet		∃Ectopic pregnar	псу				Date of delive	/ery Day Year	
Π.	dea deati	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre 9□Uni	egnant at time of known	death 5	Other (specify)						,	
P.O.	that the de led by the a detached	, h	9 Unknown							ana Dida		antributa ta	the cause of death?	
S,	uires that signed t id be det	by	Part II. Other significant condition	is contributing to	death but not re	isulting in the u	nderlying cause	given in Part	H.				bably 4 Junknown	
פֿ	n requir been si should									, ,	res 2 🗆 No			
SC	aw re	Completed								24a. Was	sy	b. Were aut	opsy findings available ompletion of cause of	
m	The l	E								perfo	rmed? 2 No	death? 1 ☐ Yes	2 No	
ta	ician: The lav certificate has rector, page 2	(U)	25. Was case referred to medical					26. Plac	ce of Death	(Check only o	nne)			
\geq	ysician: is certific director.	O B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 🗆 N	lursing Ho	me 5 🗆 Resi	dence 6 🗆	Other (Spec	ify)	
Division of Vital Records,	g Ph ter th	T ; U	27. Manny of Death	/8.4	te of Injury lonth, Day Year)	28b. Time of Injury	f 28c. Ir	ljury at Vork?		28d. Describe I	now injury oc	curred		
<u>o</u>	ath. r: Aff	atio	1 Matural 5 Pending 2 Accident investig	ation				Yes 2]No					
Vis	er de ecto by th	ertification;	3 Suicide 6 Could no 4 Homicide determine	288. Pla	ace of Injury - At ilding, etc. (Spec	home, farm, st	reet, factory, offic	е		28f. Location (City or Tox	Street and Nu vn, State)	ımbər or Rui	ral Route Number.	
	tal or s afte al Diu	Cer												
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To Examiner: On the	the best of my kr e basis of examin anner stated.	nowledge, deal nation and/or in	h occurred at the vestigation, in m	time, date a y opinion, de	and place. eath occurr	and due to the red at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)	
	the thin 2 the mple	Med	29b. Signature and title of certifier	anum	allier stated.		29c. Lice	ense number	r		29d. Date sig	gned (Month	. Day, Year)	
ł	N N		\1		V A.	MA	n a	172	30		CI	VILA	U.	
•	70			uns			Brian THO	MAS	V. TO	SEPH,	MB	2110		
	V		30. Name and address of person v	who completed co	ause of death (Ite	ON D	Print) (2	OCKU	ILL	E. K	102	085	52	
	CA	ate	31. Date filed (Month, Day, Year)		2. Registrar's Sign	nature 🥦								
	રા Regist	ate rar	SEP 24		Serena	1	Span	Cal						

PISCIOTTA, MANELINE O9/21/04 0630"

		For State of Man	-	artment of Health ar rtificate of Death		jiene •g. No. 2004	31965
Physic		Decedent's Name (First, Middle, Last) EDITH JEAN PETROS			2. Date of Dear Month	th Day / Year	3. Time of Death 2 3 52 MAP
/Medi Examil Funeral Director	4.1	4a. Facility Name (If not institution, give street and number) 5678 MT. CARMEL ROAD	In yrs. last birthday) 78 Yrs.	4b. City, Town, or Location of LA PLATA If Under 1 Year If Under 2- Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day	0 = 0 0	
D	ōN	Usual Residence of Decedent 10a, State 10b, County 1	Oc. City, Town or Lo		HOGOSI	23,119,20	10d. Inside City Limits
death with the Maryland ms 23e or 28e-f show rmat be rudified at	Direc	ARYLAND CHARLES 10e. Street and Number 5678 MT. CARMEL ROAD	LA PI	1A TA 10f. Zip Code 20646	1	Og. Citizen of What Co	
after or ite	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Event Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 Tes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	ncan Indian,
Vitin 72 bours af within 72 hours af ene. than "natural", or the medical Exemination of the medical Exemination or the medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation a kind of work done during most of DO NOT use retired)	of working	16b. Kind of Business/	
N D D	To Be Cor	12 17. Father's Name (First, Middle, Last) STANLEY JOSEPH PETROS	CAT		s Name (First, Middle, LOUISE PC		<u> </u>
re, Maryland s 1 and 2 should be filt f Health and Mental Hy itam 27 is marked oth other traumatic aveni		19a. Informant's Name/Relationship (Type, Print) MOTHER VIRGINIA MARIE, OC	D 5678	ng Address (Street and Number MT • CARMEL R	or Rural Route Number	r, City or Town, State, 2	AND 20646
timo t. Page ntment o rtant: If		20a. Method of Disposition Yunat 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee M ∩ ∩ 4 7 C	MT.CARM	osition (Name of matory or other place) EL CEMETERY 2. Name and Address of Facility	10-2-04	I.A PLATA	
Deparing Permit Popular International Popula		23a. Part 1. Enter the disease, or complications that caused th	ne death. Do not en	RAYMOND FUN	ERAL SERV	ICE, P.A. 20646	Approximate Interval Between
S8760, licate be executed Examiner and physicien and streep burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events	consequence of): consequence of): consequence of):	MSIOPTOP			19 year
I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending tage? should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moords? 1 □ Yes 2 □ Mo 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
cords, P. **requires that the been signed by should be deta	b	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause given in Part I.		bacco use contribute to es 2 € No 3 ☐ Pri	
Vital Records, sicien: The law requires to certificate has been signe lirector, page 2 should be on	Completed				24a. Was a autop: perior 1 🗆 Yes	med? death?	topsy findings available completion of cause of 2 No
on of ding Phy h. After this funeral d	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28b. Time of	nt 3 DOA Other: 4 Nurs			city)
Division attentials after death rel Diractor;	Certification:	4 Homicide Soldmines building, etc.			City or Tow		
Dir To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only 2 ☐ Medical Examiner: On the best of one) 29b. Signature and title of certifier	xamination and/or in		occurred at the time, o		to the cause(s)
		30. Name and addless of person, who completed cause of dea	ath (Item 23a) (Type	2800 Print)	CANDU	9/20/0	ExiEN
S Regis	tate	31. Date filed (Month, Day, Year) OCT 0 8 2004 January	's Signature	dones.	W(1200		,

		State of Maryland / Depar			-		e	•
	-	_ FOI	ificate of L			Reg. No	2001	31966
Discontate.		1. Decedent's Name (First, Middle, Last)			2. Date of Month	Death Da	ıy Yea	3. Time of Death
Physicia /Medica		Robert Michael Raines					18, 200	
Examine	er		^{46.} City, Town, or Bethesda		atrı		ontgome	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of		9. E	Birthplace (State or Foreign
Director		220–40–5122 TAM 2LJF 60 Yrs.	violitis Days	110dis IVIII	Ju1y	11, 1	944 V	irginia
and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition					10d. Inside City Limits
Many Hash	ţ	MD Montgomery Silver Si	pring					1 X Yes 2 □ No
th the	Jirec	10e. Street and Number	10f. Zip Code				tizen of What	Country?
IIIG Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or items 23e or 28e-f show event. I've Mod cal Exam har must be notified at	Funeral Director	3420 Island Creek Court 11 Marital Status 12. Was Decedent Ever in U.S. 13. Wa	2090		Specify Vec		USA	merican Indian.
Iter de	Fune	1 Never Married 2 P Married 1 □ Yes 2 TNo	as Decedent of Hi res, specify Cuba		orto Rican, etc.)	Black, W	
ral', o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	JYes 2. ŽŽNo	Specify:			Specify:	White
72 h	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupa nd of work done of NOT use retired	during most of w	orking	16b. F	(ind of Busine:	ss/Industry
withir ene.	duc	Elementary/Secondary (0-12) College (1-4or 5+)	Car Bui	•		A	utomot	ive
d be filed ontal Hygi ced other c event.	Be C	17. Father's Name (First, Middle, Last)		18. Mother's N			n Sumame)	
Vicini buld by Menta Menta arked etic e	10 E	Robert Elton Raines			ta Mill			
DESIGNATION E. MICE Y INTERFECT SHOULD SHOULD BE SHOULD SH			Address (Street a			_		
Health	1	20a Method of Disposition 20b. Place of Disposition cemetery, crema			Date	_		or Town, State
Pages ent of nt: If i		1 Note that it is a superior of the state o		' 0.46	21/04	Bow	ling G	reen, VA
permit. Pages 1: Department of He Importent: If iten any injury or oth		21. Signature of Funeral Service Licensee CC0321 22. 1	Name and Addres	ss of Facility Funeral	Home			
D SAESA		Mancy J. Wesselle	111 S.	Main St	. Bowli		een, V	A 22427 Approximate
		23a. Part1. Enter the difference of complications that caused the death. Do not enter shock, or head failure. It is only one cause on each line.						Interval Between Onset and Death
Physician / /Medical	ĺ	disease or condition resulting in death) a. Antonocular and a Due to (or as a consequence of):	CARI), OUP	TICULAN	17171	PASE		45/48
Examiner								
S is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
te be ysicia	cai	d						
certifical	Medi	IF FEMALE:						
death cere attendir	ian/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 E	ctopic pregnancy Other (specify)	,			23d. Date of d Month	lelivery Day Year
the de sached ached	Physician/M	1 Yes 2 No 9 Unknown	ziller (specify)					
Ords, Frequires that seen signed be nould be deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause give	en in Part I.	23e. C	oid tobacco	use contribute	to the cause of death?
w require been sig					. 1	☐ Yes 2	.□ No 3□	Probably 4 Unknown
Has by	ompieted				a	Vas an utopsy erformed?	24b. Were prior t death	autopsy findings available o completion of cause of ?
r Vital Ket ysicien: The lav is certificate has director, page 2	e Col	25. Was case referred to medical		26. Place of D	1 □ Ye	s 2 No		es 2 No
OT VICAL Physicien: 1 this certifical ral director, p	o B	examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 ER/Outpatient	3□ DOA Oth	ar	Home 5 F	-	6 ☐ Other (S)	pecify)
O € = @	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injun Worl		28d. Descri	ibe how inju	ry occurred	
Attending ar death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		Yes 2 □ No	28f Locatio	on (Street a	nd Number or	Rural Route Number.
pitet or Attenvous after deatlered Director:	ertificati	4 Homicide determined building, etc. (Specify)	n, ractory, onice			Town, State		riargi riodio riambor,
LIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	edicai C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check only 2 Medicel Exeminer: On the basis of examination and/or inve						
To the Hos within 24 h To the Fun completely	Medi	one) and manner stated.						
E3E8		P. O'Brus SMD	Di	31027		0	9-18	- 2004
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	D R.S	HEIDA	mo	2081	nth, Day, Year)
Sta	te	31. Date filed (Month, Day, Tear) 32. Registrar's Signature	/	200	0/4	((
Registr		OCT 0 8 2004 Server &	parks	/				

			1 - State Registrar	State of	Marylar	nd / Depa		t of H	lealth a	and N	ental Hyg	iene eg. No. 2	2006	31057
	Physici	ian	1. Decedent's Name (First, Midd	, ,							2. Date of Deat		Year	3. Time of Death
5	/Medi		KIRUBEL (NMN)								SEPTEMB:	ER 24	2004	15:00 PM
E	Examir	ner	4a. Facility Name (If not institutio						Location	of Death			unty of Death	
	F		National Insti			last birthday)	Be If Under	thes	da If Under	24 Hrs.	8 Date of Birth	M	ontgom	nery
н	Funeral Director		616-40-2904	1131M 2□F	13	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Nov. 4,		Cali	place (State or Foreign intry) fornia
	p.		Usuel Residence of Decedent				1				1.0 V . T ,	1770	Vall	TOTHIA
	arylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f	ecto	Ethiopia			Addis								1 ⊠ Yes 2 □ No
	with t	급	10e. Street and Number	00 77/270101	2		10f. Zip	Code			10	0g. Citizen	of What Cou	intry?
	leath	Funeral Director	Reg 14 Woreda	12. Was Deced		IS 13 1		None	spanic Ori	igin2 (Sp	acify Ves or No-		SA Race - Ameri	can Indian
(0	r Iten	표	1 X Never Married 2 Mar	ied Armed Ford	es? :⊠No						ecify Yes or No- Rican, etc.)		Black, White	
8	ral', o	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1□Yes 2	2⊠ No	Specify:			Spe	ecify:	Black
21215-0036	72 h	Completed	15. Deceder (Specify only highe	it's Education st grade completed)		16a. Deced	dent's Usua kind of wor	Occupa	ation during mos	t of work	ina	16b. Kind o	f Business/Ir	ndustry
121	within ene. than	ldμ	Elementary/Secondary (0-12)	College (1-4	lor 5+)		kind of wor DO NOT us	e retired)					
5	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Mudical Eraminar must be notified at		7 th 17. Father's Name (First, Middle,	(ast)		Stud	lent		18 Mothe	ar's Name	e (First, Middle, N		one	
an	e d fa	To Be	Solomon Demis	,									iame)	
Maryland	# B E E	-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a			in Asfav		wn, State, Zij	o Code)
	27 15		Solomon Demiss	e/Father			L4 Woi							Ethiopia
J.	- I = =		20a. Method of Disposition		1 ,	Place of Dispo	sition (Nam	e of					on - City or T	
<u>.</u> <u>E</u>	Pages ment of ant: If it		1 E Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5		are i	amily (-		· 1	9-30	-04 A	ddis	Ababa	, Ethiopia
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service	Parthe	W	Ma 4 2	Name and arshall 217 9t	Addres	Fune	ral W.	Home, In Washingt			
			23a. Part. Enter the disease, o shock, or heart failure. List	complications that cau	sed the deat	h. Do not ent	er the mode	of dying	g, such as	cardiac (or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mafasi	eke E	wmys	Sur	65m	a					Onset and Death
	/Medical Examiner		resulting in death)		as a conseq							•		
		10	Sequentially list conditions,	b	as a conseq	wanaa afti								
	ted nsit	ni-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuries deserting)	\$ Due to (of	as a conseq	derice or,								
	execunate and al-train	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):							_	
8760,	sate be executed bysician and the burial-transit	cal		d =										
89	tificat ig phy as th	led		1										
Вох	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 ∐Feta		lEctopic pre	annan cv					Date of delive	,
	the att	slcie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (spe						Month	Day Year
Q.	that the deed by the detached	Phy	9 Unknown	1										
Records,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.	· 	23e. Did toba			ne cause of death?
	ne law r has be ge 2 sh	Completed									24a. Was an autopsy			psy findings available mpletion of cause of
	± ate ±	Son									perform 1 □ Yes 2	ed? X No	death?	2 No
Division of Vital	tending Physicien: Th leath. tor: After this certificate the funeral director, pa	Be	25. Was case referred to medica examiner?					Other		of Death	(Check only one)		11.
o	Phys this al dir	٢	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		-	4 🗀 140		ne 5 Resider			y)
o	te fie	ton	1 Natural 5 Pendir	g (Month,	Day Year)	Injury	M	Sc. Injury Work	? ′es 2 □ !		28d. Describe hov	w injury occ	urred	
is:	Attending It death. octor: After by the fune	fica	3 Suicide 6 Could	not be 28e. Place of	Injury - At ho	ome, farm, stre				-	28f. Location (Stre	eet and Nu	mber or Rura	I Route Number.
á	of or after	Certification;	4 Homicide	building	, etc. (Specif	y)					City or Town,	State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physicien: To the be Exeminer: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a restigation,	it the timi	e, date and inion, deat	d place, a	and due to the cau and at the time, dat	use(s) and te and plac	manner as si e, and due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifie	- 08					number		29		ned (Month,	
)			(Cutage	97			D	00	615	08		4/2	4/04	•
1	20 m		30. Name and address of person	who completed cause	of death (Item								0	
	10		Chris Gamper,				LO CEN	TER	DRIV	Е, В	ETHESDA,	MD	20892	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	Spen	W							

			For State Registrar	St	ate of M		d / Depa		t of H	lealth a	and M	lental Hy		004	319	58
			Decedent's Name (First, Midd	le, Last)								2. Date of De	ath		3. Time of	Death
	Physici: /Medic		Gladys Eloise	Stewa	art							Month Septemb	Day Der 20	Year 2004	9:01	м ф
	Examin		4a. Facility Name (If not institution)		4b. City,	Town, o	Location of		P		ounty of Death		
			Holy Cross Ho	spital	L			Sil	ver	Sprin	ng		Me	ontgome	ery	
	Funeral Director		5. Social Security Number 217-44-4642	6. Sex 1 ☐ M		ge (In yrs. i	last birthday) 1 Yrs.	If Under Months	1 Year Days	If Under Hours	B Sim	8. Date of Bir (Month, Da Nov 22	th V, Year) 191	9. Birth Cou Mis	place (State o intry) SISSIP	r Foreign pi
	D .		Usual Residence of Decedent			100 Cib	, Town or Lo									
	aryia shov	_	10a. State 10b. County												10d. Inside Ci 1 ☐ Yes	•
	28a-f	Director		gomery	7	5.	ilver									
	a or i		10e. Street and Number 927 Gable Co					10f. Zip	2090	\ 7			10g. Citize	n of What Cou	intry ?	
	eath	Funeral	11. Marital Status		Vas Decedent	t Ever in II	S 13				ain? (Sn	ecify Yes or No	- 14	USA Race - Amer	ican Indian	
	ter d	F	1 Never Married 2 Ma	A	med Forces	?	0. 13.	If Yes, spec	ify Cuba	in, Mexicar	i, Puerto	Rican, etc.)	13	Black, White		
99	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examinatinust be multipad at	5	3 ∰Widowed 4 ☐ Divorce	. If	Yes, Give ear or Dates:			1 ☐ Yes	2⊠ No	Specify:			S	pecity: Whi	te	
21215-0036	i 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show idical Examinar hast be natified at	ted	15. Decede	nt's Education	n n		16a. Dece	dent's Usua	1 Occup	ation		·	16b. Kind	of Business/I	ndustry	
215		pie	(Specify only higher Elementary/Secondary (0-12)	Ť-	college (1-4or	5+)	life.	kind of wo DO NOT us	se retired	dunng mos i)	t or work	ng				
7	e filed within Il Hygiene. other than vent, Ibe M	Completed			4		Но	omemak	cer					wn Hom	e	
g		Be	17. Father's Name (First, Middle									First, Middle		imame)		
S	should be nd Mental n marked c	၉	James Madiso				,					Randal				~
Maryland	2 sh and lam		19a. Informant's Name/Relation	ship <i>(Type, F</i>	Print)							al Route Numb				
as a	as 1 and 2 should b of Health and Ments (Item 27 ia marked rother traumatics		Lynne J. Boile 20a. Method of Disposition	au/ Gu	ardian		2200 lace of Dispo			Highv		#300,				
Baltimore,	Sept = 50		1 Burial 2 Cremation	3 Remo	val from State	Me.	emetery, crei	natory or o itan	ther plac	(8)		nber 24,	20c. Loca	tion - City or T	own, State	
ŧΞ	t. Pa		'4 □Donation 5 □ Other (remato	ry				004	xandria, Virginia		nia	
Bal	permit. Pagas 1 Department of H Important: If Its any injury or ot once.		21. Signature of Funeral Service	Licensee	ole		22. Name and Address of Facility Francis J. Collins Funeral H 500 University Blvd, W, Silv						Home	ver Spring, MD		0901
П			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complicatio t only one ca	ns that cause use on each	ed the death line.	n. Do not en	er the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Bet	ween
4	Physician		Immediate Cause (Final disease or condition	a G	allbla	dder	Maligr	ancv							Onset and t	
	/Medical Examiner		resulting in death)		Due to (or a			- 11 C V								
	LAUIIIIICI		Sequentially list conditions,	b. —	D											
	pe:	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or a	s a conseq	uence or):									
	be executed sicien and burial-transit	хаг	that initiated events resulting in death) Last	c	Due to (or a	s a conseq	uence of):									
09,	sicien buris	caiE														
68760,	ficate pphysics the l			d												
X	death certificate be executed e ettending physicien and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		yes, outcom			7-1					236	d. Date of deliv	ery	
m.	death e ette	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4	Live birth			∃Ectopic pr ∃ Other <i>(sp</i>						Month	Day	Year
P.0	that the de lad by the detached	hys	9 Unknown	9	Unknown											
	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant condit	ons contribu	ting to death	but not res	ulting in the u	nderlying c	ause giv	en in Part I.		23e. Did t	obacco use	contribute to	the cause of d	leath?
ord	v require been si should b											1 🗆	Yes 2⊠I	No 3□Pro	bably 4 □l	Jakaowa
Records,	e law requ has been je 2 shoul	Completed										24a. Was		24b. Were aut		
Ä	The Tate his page	mo										auto perfo	rmed?	death?	ompletion of a 2□ No	ause or
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	al L						26. Place	of Death	Check onl				
of V	d is	To	1 ☐ Yes 2 🛣 No	Hospi	tal:	trent 2	ER/Outpatie	nt 3 DC	Oth	er: 4 □ Nu	rsing Ho	me 5□Resi	dence 6 [□Other (Speci	fy)	
									8c. Injur Wor	y at		28d. Describe				
Sio	See Place of Injury - Athome, building, etc. (Specify)							М	1 🗆	Yes 2□	No					
Division								reet, factory	, office			28f. Location (City or To	Street and f wn, State)	Vumber or Rui	ai Route Num	ber,
	orsal oral D		Y-													
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier 1 [™] Certify (Check only 2 Medica one)	Examiner:	n: To the bes On the basis and manner s	of examina	wiedge, deat tion and/or in	h occurred vestigation	at the tin , in my o	ne, date an pinion, dea	id place, ith occurr	and due to the ed at the time,	cause(s) ar date and pl	nd manner as a ace, and due	stated. to the cause(s	.)
	To the To the Comp	Σ	29b. Signature and title of certifi	1		,		.	. Licens	e number			29d. Date s	signed (Month,	Day, Year)	
1	3		Jam P.	Kar	mas	Kar	- MS	D.	D20	062			Sept	ember :	21, 200	04
			30. Name and address of perso	who comple	eted cause of	death (Iten	1 23а) (Туре,	Print)	c, S:	iler	Spri	ng, MD	20910			
E	Sta Registi		31. Date filed (Month, Day, Yea SEP 2 4	2004		trar's Signa	ture	Spo	uks				-			

		1	For State Registrar	State of N	/larylan	-	artment rtificate					giene Reg. No.?	101	31969
	Physicia		1. Decedent's Name (First, Middle, Last Joseph J. Strnad)							2. Date of De Month	Day	Year	3. Time of Death 12:30 A ^M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and numbe	r)		4b. City,	Town, or	Location		Septeml		nty of Death	
	Examin	C1 ,	8801 Walnut Hill F		,		Che	vv C	hase				tgome	
	Funeral		5. Social Security Number 6. Se			last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign
	Director		506-12-1300	M 2□F	83	Yrs.	I I I I I I I I I I I I I I I I I I I	Juyo	7.04.0		May 14	, 1921	Nebi	raska
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Maryl f ehc	ō	Maryland Montgome	rv	Che	vy Ch	ase							1 ☐ Yes 2X No
	r 28a	Funeral Director	10e. Street and Number			, , , , ,	10f. Zip	Code				10g. Citizen	of What Cou	intry?
	h with	a D	8801_Walnut Hill	Road			2081	15				Unite	d Stat	es
	ems a	ner	11. Marital Status	12. Was Deceder Armed Force		S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)		Race - Amer Black, White	ican Indian,
98	or its		1 Never Married 2 Married	1 X Yes 2 [If Yes, Give	[□] N°1940	_	1□Yes 2		Specify:			1		
21215-0036	72 hours after death with the Maryland natural, or items 23a or 28a-f show disal Examinat must be routified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates	1968	3	dent's Usua	I Occupa	ation		"	1	ecify: Whi	
5	in 72 n "n ledic	Completed	(Specify only highest grad	le completed)	- \	(Give	kind of wor DO NOT us	k done c	turing mos	st of worki	ing		d Sta	•
212	Jiene.	mo	Elementary/Secondary (0-12)	College (1-4o 4	r 5+)	Commi	ssion	ed	Offic	cer			rmy	
b	al Hyg	Be C	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden Sun	name)	
<u>Va</u>	Menta	2	Frank Strnad						Mary	7 Shr	amek			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examination at months and the rolling at		19a. Informant's Name/Relationship (7				-				I Route Numb	•		
e,	l and lealth sm 27 sher t		Esther Strnad/Wife 20a. Method of Disposition	2	20h P	8801			ill		Chevy		MD . 2	
ğ	dy or of H		1 ☐ Burial 2 X Cremation 3 ☐		te Mor	emetery, cre 1 120 me	matory or or TV	ther plac	1 1	Septe	ember			
Baltimore,	it. Partmer		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen:	A	C	remato	orium,	Inc	s of Facili		2004			aryland
Ba	permit. Pages. Department of H Important: If Ite any injury or of once.		phale &	C.	м013								Wisco	neral Home/ nsin Avenue
b			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caus one cause on each	ed the deat line.	h. Do not en	ter the mod	e of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a		c Canc	er							2yrs.,4mos.
	Examiner		1	Due to (or a	as a conseq	uence of):								
	Trick)	ē	Sequentially list conditions, if any, leading to immediate	b. Dua to (or r	as a ounswy	uanca (dly							_	
	be executed sician and burial-transit	Examiner	Tarry, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
oʻ	an an rial-tr	Exa	resulting in death) Last		as a conseq	uence of):								
8760,	ate hy:	lical		d										
9	eath certific attending pl	Physician/Medical	IF FEMALE:	00- 11										
Вох	death certific e attending p id for use as '	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Feta	I death 3	□Ectopic pr					23d.	Date of deli- Month	very Day Year
Ö	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknowr		lea(III 5)	_ Other (sp	ecity)		<u> </u>				
٣.	that the bod by deta		Part II. Other significant conditions co	ontributing to death	but not res	ulting in the	underlying c	ause giv	en in Part	Ι.	23e. Did	tobacco use c	contribute to	the cause of death?
Vital Records,	The law requires that te has been signed b age 2 should be deta	ed by									1 🗆	Yes 2XIN	o 3 □ Pro	bably 4 Unknown
000	law requir as been si 2 should	Completed									24a. Was			opsy findings available
R	The la ate ha	шо									auto perfe 1 Tyes	psy ormed? 2 2 No	death?	ompletion of cause of
İta	sician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?						26. Plac	e of Deatl	(Check only			
of V	di Si	5	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpa		ER/Outpatie			4 141	ursing Ho	me 5 🙀 Res	idence 6 🗆	Other (Spec	ify)
		inol.:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time Injury		8c. Injun Worl	k?		28d. Describe	how injury oc	curred	
isio	Attending r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		Injuga . At h	ome form c	M Iront factor		Yes 2□		28f Location	Street and No	um ber or Pu	ral Route Number.
Division	al or Attends after death	Certification:	4 Homicide determined	building,	etc. (Specif	y)	reer, ractory	, onice				wn, State)	unider of Au	rai nobie Nbillber,
	To the Hospital or within 24 hours after To the Funeral Dir.	edicai (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the be niner: On the basis and manner	s of examina	owledge, dea ation and/or i	th occurred nvestigation	at the tin	ne, date ai pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. Licens	e number			29d. Date sig	gned (Month	, Day, Year)
			I Jua I:	, MD				0006	0286			Septem	ber 2	2, 2004
1	OTI		30. Name and address of person who											
				01 North			Baltin	nore	, Mar	ylan	d 21231			
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 4 20		istrar's Signa	ature 49	Spe	uks						

		State of Maryland / Department of Health	
	Dharisina	Decedent's Name (First, Middle, Last)	2. Dete of Death 8. Time of Death
	Physician /Medical	BINA ROJZA SZPILBERG	SEPTEMBER 23, Year SEPTEMBER 23, 2004 6:50AM Town, or Location of Death 4c. County of Deeth
aw.	Examiner	to I could rectife (if not included, give of our and training)	OCKVILLE MONTGOMERY
	Funeral Director	286-40-6684 1 M 2 F 94 Yrs. Months Days Hou	der 24 Hrs. In the second of Birth Pay, Year MAY 21, 1910 9. Birthplace (State or Foreign Country) POLAND
	ow #	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-fah	MARYLAND MONTGOMERY ROCKVILLE	1 ∄ves 2 □ No
	ifter deeth with the Mei r fems 23a or 28a-f s ciner must be notified Funeral Director	10e. Street end Number 6121 MONTROSE ROAD 10f. Zip Code 20852	UNITED STATES OF AMERICA
020	be filed within 72 hours efter deeth with the Merylend tel Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1	
Baltimore, Maryland 21215-0020	ed within 72 hours e ygiene. er than "natural", o it, the Medical Exa. Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired) HOMEMAKER	most of working 16b. Kind of Business/Industry OWN HOME
land 2	B € g € w	17. Father's Neme (First, Middle, Last)	other's Name (First, Middle, Maiden Surname) HILDA ROTHOLDS
lary	2 9 9 5	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	imber or Rurel Route Number, City or Town, State, Zip Code)
e, N	l end feelth m 27 her tu	RITA HILLER - DAUGHTER 11408 NAIRN ROAD 20a. Method of Disposition (Name of Disposition (Nam	Date 20c. Location - City or Town, State
mor	Pages ent of nt: # lk	1 ABurial 2 Cremation 3 Aemoval from State 4 Donation 5 Other (Specify) 1 ABurial 2 Cremation 3 CHISUK EMUNA CEMETE	ERY 09/24/04 HARRISBURG, PA
Balti	permit. Pages 1 end Depertment of Heelth Important: If Item 27 any injury or other tr once.		FUNERAL DIRECTION, INC LE PIKE, ROCKVILLE, MD 20852
		23a. Pert1. Enter the disease, or complications that caused the fath. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	n as cardiac or respiratory arrest, Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. ### J3 CHEMIC CARDIOA Due to (or as a consequence of):	Onset and Death
	sit ad		
ç,	tificate be executed g physician end es the bunel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Due to (or as e consequence of):	
κ 68760,			
Box	eath cert ettendin for use clan/N	U.	
P.O.	d by the detection	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in P	23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law requires that the death certificete be executed sate hes been signed by the ettending physician end page 2 should be deteched for use as the buniel-trensit Completed by Physician/Medical Examin		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
l Re	The la		1
Vita	Physician: r this certific aral director,	25. Was case referred to medical examiner?	Place of Death (Check only one)
of	Physic eral dire	1 Linpatient 2 EH/Outpatient 3LiDOA 4	Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Division	tal or Attending P is effer death. al Director: After t led in by the funers Certification:	1 Netural 5 Pending investigation 2 Accident 3 Suicide 4 Homic	2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
ā	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion,	
	o the F o the F omplet	29c. License numl	ber 29d. Date signed (Month, Day, Yeer)
	F ≱ F ŏ	1 A mis. 0180	84 SEPT. 22, 2004
	3	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)	84 SEPT. 22,2004 RD, Rockville, 11020852
	State	21 Data filed (Month Day Vear) 1 22 Denistrer's Signature	

DHMH 16 Rev 6/95

SZPILBERG

		1 - For Stete Registra MEND #23a(b)&Pa	State of Maryland / DepartIIperMD9/24/04,B,MGe		Mental Hygier Reg. N	0001	21071
Physic /Medi		Decedent's Name (First, Middle, Last) PETER	SEI	MENIUK		Day Year 1, 2004	3. Time of Death 10:34P.
Exami		4a. Facility Name (If not institution, give s 4702 Brandon La		4b. City, Town, or Location of Death Beltsville		4c. County of Death Prince G	eorge's
Funeral Director		5. Social Security Number 6. Sex 217–16–0998 1X	M 2 F 7. Age (In yrs. last birthday 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Apr. 27, 19	ir) Cour	
Maryland -f show	tor	10a. State 10b. County Maryland Prince Ge	orge's Beltsvi			1	10d. Inside City Limits 1 ☐ Yes 2 No
with the 3a or 28a	I Direc	10e. Street and Number 4702 Brandon Lane		10f. Zip Code 20705		Citizen of What Cour nited Stat	
us after death il', or itams 2 xaminar mu	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 No IT 'es, Give Year or Dates: WII	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I thailth and Mental Hygiene. Itam 27 is marked other than "natural, or itams 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (2-12)	cation 16a. Dece (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) iculturist	ring	Kind of Business/Indept. of Ag	·
should be filed within of Mental Hygiene. marked other than imatic event, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last) Jakeim	Semeniuk	18. Mother's Nam Mary	e (First, Middle, Maide		
nd 2 should be file alth and Mental Hy 27 is markad oth r traumatic evant	-	19a. Informant's Name/Relationship (Ty). Bernadette J. Seme	and and a series	ing Address (Street and Number or Rur Brandon Lane Belt			,
permit. Pages 1 and 2 Department of Health Important: If Itam 27 I any injury or other tre		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State 20b. Place of Disp cemetery, cre Gate of	osition (Name of ematory or other place) Heaven Cemetery 9/		Location - City or To	
permit. Departr Importe any inju		21. Signature of Funeral Service License	Bugeradt !	22. Name and Address of Facility Donald V. Borgward 1400 Powder Mill Ro	t Funeral d. Beltsvi	Home, P.A lle, Mary	land 20705
Fnysician /Medical Examiner be executed bull strength and street partial street partial street from the street	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Hydrone; h: Due to (or as a consequence of): Due to (or as a consequence of):	Renal Failu			
death certifi e attending id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
es De	by	Part II. Dther significant conditions cor Diverticulosis	tributing to death but not resulting in the with Gastrointe			co use contribute to the	he cause of death?
: The law requires that the cate has been signed by the page 2 should be detached	Completed				24a. Was an autopsy performed:	prior to co	opsy findings available impletion of cause of 2 \(\text{No} \)
Attanding Physician: The law requir r death. sctor: After this certificate has been si by the funeral director, page 2 should	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 ER/Outpatie	ont 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 X Residence 28d. Describe how in		y)
2 9 2 6	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		al Route Number,
To the Hospital of within 24 hours af To the Funaral D completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
TO Within	M	29b. Signature and title of certifier	Kudulas	29c. License number D0036716		Date signed (Month, ptember 22	
7		30. Name and address of person who co Andrew Kundrat, I	mpleted cause of death (Item 23a) (Type $_{ m A_{ullet}D_{ullet}}$ 8317 Cherry I	ane Laurel, Maryla	and 20707		
S Regís	tate trar	31. Date filed (Month, Day, Year) SEP 2 4 20	32. Registrar's Signature	Spark			

			State of Maryland / I						
			for State of Maryland / 1 For State Registrar MEND#7perFH9/24/04, PMW, MoCo 1. Decedent's Name (First, Middle, Last)	Certific	ate of L	Death		g. No? 1) 1 L	3:972
П	Physici	an					2. Date of Death Month	Day Year	
	/Medic	al	Abraham Silverman 4a. Facility Name (If not institution, give street and number)	4h (City Town or	Location of Dea	Sept.	12, 2004 4c. County of De	1:12 P M
	Examin	er	Laurel Regional Hospital		ure1	Essential of Both		Prince Ge	_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If U	nder 1 Year	If Under 24 Hr Hours Mir			inthplace (State or Foreign Country)
	Director		578-28-3415 Raw 227 -79	Yrs.			11-25-19		shington, DC
	yland 10W		10a. State 10b. County 10c. City, Tow	vn or Location					10d. Inside City Limits
	e Mar	ctor	Maryland Prince George's Lau	rel					1 X Yes 2 □ No
	with th	Dire	10e. Street and Number	10f	. Zip Code		10	og. Citizen of What C	Country?
	eath v	erai	14923 Belle Ami Drive 11. Marital Status 12. Was Decedent Ever in U.S.	13 Was D	20707	spanic Origin?	Specify Yes or No-	U.S.A.	nerican Indian
9	after d	by Funeral Director	Armed Forces? 1X Never Married 2 Married 1 Yes 2X No				(Specify Yes or No- erto Rican, etc.)	Black, Wh	
9	ural', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		s 🌠 No	Specify:			nite
7	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28e-f show than "Medical Examinar most be notified at	Completed	(Specify only highest grade completed)	 Decedent's (Give kind of life. DO NO 	Usual Occupa f work done a T use retired	ition <i>furing</i> most of w)	orking	16b. Kind of Busines	s/Industry
212	d with giene.	omi	Elementary/Secondary (0-12) College (1-4or 5+)	Sales	,			Liquor St	ore
D	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle, M	faiden Sumame)	
<u> </u>	d Men narke	2	Harry Silverman 19a. Informant's Name/Relationship (Type, Print) 19t		(С		s Krasofsl		7.0.11
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or liems 23a or 28e-1 show amy injury or other treumatic avent, the Medical Examiner must be notified at ance.					vertree	Rural Route Number, Rd. Sun	Lakes, AZ	
re,	item		20a. Mathod of Disposition 20b. Place of camere	of Disposition ery, crematory	(Name of or other place	g)	_	20c. Location - City o	
altimore,	Page ment c		I Dutial 2 Distination 3 Distinuyal noni State				4/2004 Fa	alls Churc	ch, VA
Balt	permit. Depart mport iny inj		21. Signature of Funeral Service Licensee				ines-Rina		MD 2000/
	40260		23a. Cart 1. Enter the disease, or complications that caused the death. Do						ng, MD 20904 Approximate
7	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			,	,,,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Congestive near a. Due to (or as a consequence		Luic				
	Examiner	_	Saquantially list conditions. Arteriosclerot		diovas	cular D	isease		
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	01):					
o,	te be executed ysician and he burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence	of):					
3760,	a × a	lical	d						
39 xo	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					70	
\mathbf{m}	leath certific attending p	cian	in the past 12 months?	n 3∏Ectop 5 ☐ Other	ic pregnancy			23d. Date of de Month	elivery Day Year
o.	t the c by the	hysi	1 Yes 2 No 9 Unknown 9 Unknown						
S, D	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting i	in the underlyi	ng cause give	on in Part I.			o the cause of death?
ord	w require been si should I	eted	Cerebrovascular Accident				1 ∐ Ye	s 2 No 3 F	robably 4X Unknown
Records,	The law cate has b	Completed					24a. Was an autopsy perform	prior to	completion of cause of
		0	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2	No 1 ☐ Ye	
Division of Vital	ttending Physician: leath. tor: After this certifica the funeral director, t	To B	examiner?	utpatient 3	DOA Othe	I.P.	Home 5 Reside		ecify)
0 0	ing Pt Viter th uneral		27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work		28d. Describe hor	w injury occurred	
Sio	= 00 >	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for	Arm street far		res 2□No	28f Location (Str	eet and Number or F	Pural Route Number
<u>≥</u>	i Lite	Certification:	4 Homicide determined building, etc. (Specify)	a, 511001, 141	aory, omoe		City or Town,		and record veriles,
	To the Hospitel or within 24 hours afte No To the Funerel Dir completely filled in	edicai C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination are	e, death occur	red at the tim	e, date and place	ce, and due to the ca	use(s) and manner a	s stated.
	the H hin 24 the F mplete	Medi	one) and manner stated.	To or investiga					
	5 × × × × × × × × × × × × × × × × × × ×		29b. Signature and title of certifier	1	29c. License			d. Date signed (Mon	
•	5		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	D2472	1		09-13-2004	
			Syed Sadw 14333 Laurel Bowie Rd.		208 La	urel, M	D 20708		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 4 2004 32. Registrar's Signature	9 1	ocks!	,			
	riegisti		ULI NIZ LUUT		-				

Physician /Medical Examiner

Funeral **Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturat, or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examt extrans be inclined at apprise.

Physician /Medical Examiner

To Be Completed by Funeral Director

Pleas	se Type	or Print i	n Blac	k Inde	lible Inl	k. Ensu	re Al	I Copies A	re Lea	ible.	
_ For								lental Hygic	_		
1 - State Registrar						Death		, ,	. NG.	n I. 9 I	070
Decedent's Name (First, Middle	, Last)							2. Date of Death	tree and		me of Death
FREDERICK MA	RTIN SN	1ITH						Septemb	er 2	3 ,°2 ′004	0633₄
4a. Facility Name (If not institution	, give street an	d number)		4b	. City, Town,	or Location of	of Death			y of Death	
Memorial						aston			Ta1	bot	
5. Social Security Number	6. Sex 1 X M 2 □	le l	yrs. last bir		Under 1 Yea onths Days		Min.	8. Date of Birth (Month, Day, Y		9. Birthplace (S Country)	tate or Foreign
188-24-4356 Usual Residence of Decedent	· · · · · · ·		73	113.				JUNE 18	1931	PA	
10a. State 10b. County		10	c. City, Tow	n or Location	n					10d. Insi	de City Limits
MD TA	LBOT		ΕΛ	STON						1 [Yes 2 XNo
10e. Street and Number	прот		112		Of. Zip Code	-		100	. Citizen of	What Country?	
35 PARK LANE						21601			U	ISA	
11. Marital Status	12. Was	Decedent Ever	in U.S.	13. Was	Decedent of	Hispanic Ori	gin? (Spe	ecify Yes or No-	14. Ra	ce - American India	an,
1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 📉	Yes 2 No es, Give or Dates:			res 2 X No	ban, Mexican Specify:	i, Puerto	Hican, etc.)		ack, White, etc.	
15. Decedent		atad)	16a	. Decedent'	s Usual Occu	upation e during most	t of words	16	b. Kind of E	Business/Industry	
(Specify only highes Elementary/Secondary (0-12)	1	ege (1-4or 5+)		life. DO N	OT WORK GONE OT use retir	ed) ed)	or worki	ing			
12	.]	2	PA	TIENT	SERV	ICES RI				LATI	
17. Father's Name (First, Middle,						18. Mothe	r's Name	e (First, Middle, Ma	iden Suma	me)	
CLYDE MARTIN	SMITH S	SR				EL.	IZAB!	ETH CHRIS	NAMT		
1 Burial 2X Cremation 4 Donation 5 Other (S) 21. Signature of Funeral Service 23a. Part1. Enter the disease, or shock, or heart failure. List	complications	ZCE R;	HESAP	PEAKE 22. Na FEL 200 not enter th	me and Addi LOWS, S. HA e mode of dy	ress of Facility HELFEN ARRISON	y NBEII N ST cardiac c	. ,	M FUN MD 21	Approx	E PA
Immediate Cause (Final disease or condition		ACUTE	NO	ON G	2 WA	VE R	1400	CARDIAC	INF	ARCINE Onset	and Death
resulting in death)	Du	e to (or as a co	nsequence	of):							
Sequentially list conditions,	b		TENS		· · · · · · · · · · · · · · · · · · ·						
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ue to (or as a co	nsequence	or):							
that initiated events resulting in death) Last	c	ue to (or as a co	пѕепцепсе	of):							
				0.,.							
11	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 0	s, outcome of pi Live birth 2 Pregnant at time Unknown	Fetal death		opic pregnancier (specify)	су				ate of delivery onth Day	Year
Part II. Other significant condition	ns contributing	to death but no	ot resulting i	n the under	lying cause g	iven in Part I.		23e. Did tobac	co use con	tribute to the cause	e of death?
					-			1 ☐ Yes	2 🗆 No	3 ☐ Probably	4 WUnknowr
								24a. Was an			
								autopsy performe	d2	Were autopsy find prior to completion death? 1 Yes 2 No	
25. Was case referred to medical examiner?								Check onl one			
1 ☐ Yes 2 No	Hospital:	1 NInpatient	2 ERVO		□ DOA O	ther: 4 Nu	rsing Ho	me 5 Residenc	e 6 □0t	her (Specify)	
27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9	Date of Injury (Month, Day Ye		Time of Injury	28c. Ing	ury at ork? □ Yes 2 □ N		28d. Describe how	injury occu	rred	
3 Suicide 6 Could r 4 Homicide determ	ned 280.	Place of Injury - building, etc. (S	At home, fa	arm, street,	factory, office	•		28f. Location (Stree City or Town, S	et and Num State)	ber or Rural Route	Number,

Medical Certification; To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 104

D0059487 Thupsetses M.D.

JOHN BOTSIS M.D.

31. Date filed (Month, Day, Year)

SEP 2 4 219 S. WASHINGTON ST EASTON, MD 21601

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar		State of Ma	ıryland /	-	rtment of tificate of		Mental H	ygiene Reg. Ne.	nni	31971
	Physicia /Modis		1. Decedent's Name ((First, Middle, Last))	SA	AGEND	ОКРН		2. Date of D Month SEPTEM	Death Dav	8 20	
	/Medic Examin	-	4a. Fecility Name (If r	not institution, give	street and number)				or Location of Dea		4c.	County of D	eeth
					TERANS HON		5 1 a 5 1 1		TTE HALL			. MAR	
	Funeral Director		5. Social Security Nur 062–12–81	00	7. Age M 2□ F	(In yrs. last l	Yrs.	Months Day:			Day, Year)	19 NI	Birthplace (State or Foreign Country) EW YORK
	land ow	1	Usuel Residence of D 10a. State	10b. County		10c. City, To	wn or Loc	ation	· · · · · · · · · · · · · · · · · · ·		-		10d. Inside City Limits
	Many Hed	tor	MD	ST. MARY'	s	CHARL	OTTE	HALI.					1 ☐ Yes ¾∑ No
	ith the or 28	Director	10e. Street and Numb					10f. Zip Code	3		10g. Citi	zen of What	Country?
	ath w	ral	29449 СНА					2062				S. A.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-1 show or other treumatic event, Ita Medical Exactinat must be rediffed at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	d 2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	lo	If	as Decedent of Yes, specify Cu ☐ Yes 2💢 No	Hispanic Origin? (ban, Mexican, Pue o Specify:	Specify Yes or N into Rican, etc.)	10-	Black, W	merican Indian, Thite, etc.
21215-0036	72 hou	ted	(Saccife	15. Decedent's Edu	cation		a. Decede	ent's Usual Occi	upation	a deia a	16b. Kii	nd of Busine	
2	ithin 7	Completed	Elementary/Second		College (1-4or 5		life. D	O NOT use retir	•				
	lled w lygier her th	Co	17. Father's Name (F			BU	SINE	SS MACH	INES MANA	GER		MPUTER	L
and	d be frequently be to be to ever	o Be	LEON THEO		ENDORPH					RAPSER	e, maiden	Sumame)	
Maryland	S should be filed withir and Mental Hygiene. Is marked other then eumatic event, I.a.M.	ပ	19a. Informant's Nam			15	9b. Mailing	Address (Stree	et and Number or F		ber, City or	r Town, State	e, Zip Code)
	and 2 lealth a m 27 ls		LAUREL S.	O'HEARN/	DAUGHTER	6	425	SUNNYSII	DE DRIVE	BRYANTO	WN M	ARYT.AN	D 20617
Baltimore,	Pages 1 anneat of He ent: If Item ary or oth			osition Cremation 3 F 5 Other (Specify)	Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other pi		TEMBER	20c. Lo		or Town, State
Balti	permit. Page Department of Importent: If eny injury or		21. Signature of Fund	Prail Service Licens	e Sets	M0064	22.	Name and Add	ress of FacilityL. K 489 KNI	HAROLD 1	POOLE	FUNL.	SERV.&CREMATO
60,	Physician /Medical Examiner but and physician and street private is the parial-transit	al Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list condition, leading to immediate. Enter Underh Cause (Disease or in that initiated events resulting in death) La	ditions, negliate ying signry	Due to (or as a Due to (or a) Due to (or	S + C a consequence a consequence	CC ea of):		Cancer		unosi,		Approximate Interval Between Onset and Death On ore then Folly Months
O. Box 68760,	t the death certi by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome of the company	2 Fetal dea		Ectopic pregnan Other (specify)	су		2	23d. Date of o	delivery Day Year
ds, P	w requires that s been signed by should be deta		Part II. Other signification Demer		ntributing to death bu	ıt not resulting	g in the und	derlying cause g	oven in Part I.				o to the cause of death? Probably 4 Punknown
of Vital Records,	10 10	Completed by	Anaer	mia	bnillati	on.				per	s an opsy formed?	24b. Were prior to death	
/ita	ysician: The is certificate his director, page	Be	25. Was case referre	ed to medical						eath (Check only			
	Attending Physician: r death. ector: After this certific by the funeral director.	atlon: To	1 ☐ Yes 2 ☑ N 27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	1 Inpatie	y Year) 28b	Outpatient Time of Injury	28c. ln		Home 5 Res			pecify) LIVENG
Division	in the	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, (Specify)	farm, stre	et, factory, office	Э	28f. Location City or To	(Street and own, State)	d Number or	Rural Route Number,
	he Hospitel n 24 hours a he Funerel E pletely filled i	edical (29a. Certifier 1 (Check only 2 one)	☐ Certifying Phy 2☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination a	lge, death and/or inve	occurred at the astigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) a, date and	and manner place, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and ti	the of certifier	n 6.	A			nse number		29d. Date	signed (Mo	onth, Day, Year)
			1 C	ym	- IW	-and		D:	5065	3.	SEPT	EMBER	18, 2004
1	o hel		30. Name and addres						OAD HIC.	DB477	m 00=	,,,	
ı i	BIDE	•	GYAN C. 31. Date filed (Month)		M.D. 5851				UAD #16]	DEALE, M	w 207	51	
	Sta Registi	-	The state of the s	SEP 2 7 2	1004	r's Signature	Y A	Seed of					

Viola M. Sirk 04-6094 AKG

094	ŧ		Far	State of Maryland / Depa	artment of Health and M	ental Hygien	e
			For State Registrar		tificate of Death	, ,	
			Decedent's Name (First, Middle, Last,		tineate or Beatin	2. Date of Death	3. Time of Death
	Physici	an	- 11.			Month D	ay Year
	/Medic			irk			21, 2004 7:37 P ^M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			9924 Pine Tree Roa	ıd	Woodsboro		Frederick
	Funeral		5. Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) 9. Birthplace (State or Foreign Country)
	Director		213-40-4963	M 2X F 62 Yrs.		March 25,	1942 Maryland
	70		Usual Residence of Decedent				
	ylan ylan		10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	M - M	ρ	Maryland Frederic	k Woodsl	horo		1 ☐ Yes 2 No
	288	Director	10e. Street and Number	woods:	10f. Zip Code	10g. C	Citizen of What Country?
	Net Page		002/ Dim Tone De	_ 3	01700		
	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show deat Ever, it art must be notified at	Funeral	9924 Pine Tree Ro		21798 Was Decedent of Hispanic Origin? (Spe		nited States 14. Race - American Indian,
	er d	Ę		Armed Forces?	f Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White, etc.
36	s aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√√No If Yes, Give	I ☐ Yes 🏋 No Specify:		Specify:
21215-0036	hour nurs	D D		Year or Dates:			White
,	CV 65 CM	ete	15. Decedent's Edu (Specify only highest grad	le completed) (Give i	lent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Industry
2	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		
7	e filed w Il Hygiel othar ti vant, In	Completed	11		Homemaker		Own
힏	be filed within 7; ital Hygiene. id other then "n. event, Ins Medi	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maide	an Sumame)
<u>la</u>	Mental Mental arked o	10	Jesse C. Merce	er	Sarah	E. Morn	ingstar
Maryland	2 should and Men Is marke sumatic	i i	19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Mailin	g Address (Street and Number or Rura	Route Number, City	or Town, State, Zip Code)
	s 1 and 2 should if Health and Mer Itam 27 is marke other traumatic		David L. Sirk, hu	ishand 9924	Pine Tree Road Wo	odehoro	MD 21768
ည်	Health tam 27 l		20a. Method of Disposition	20b. Place of Dispos	sition (Name of D		Location - City or Town, State
ō	0 0		tXXBurial 2 ☐ Cremation 3 ☐ F	removal from State	natory or other place)		(Water
Baltimore,	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Specify)	1			rmont, Maryland
3al	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	99 22	. Name and Address of Facility Stau	ffer Fune	ral Homes, P.A.
			Brodley 4 Sm	1	ozi Upossumtown Pi	ke Frede	rick, MD 21702
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death. Do not enter be cause on each line.	er the mode of dying, such as cardiac o	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	4.4	cardio Vascular		Onset and Death
7	/Medical		resulting in death)	Due to (or as a consequence of):	CAD ILLY OF GOOD	, , , , , , , , , , , , , , , , , , ,	
	Examiner			,			
	,	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):			
	pet nsit	Examine	cause. Enter Underlying Cause (Disease or injury				
	xecu and II-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	a E					
87	cate ohys the	dlcal		d			
9		Me	IF FEMALE:				
Вох	death certifi e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of delivery
	000	Physiclan/Me	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		Month Day Year
P.0	at the de by the tached	hy	9 KUnknown				
	The law requires that the ate has been signed by thoage 2 should be detache	by F	Part II. Other significant conditions co	ntributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	quire n sig					1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 🐧 Unknown
00	w require been si	Completed				24a. Was an	24b. Were autopsy findings available
36	has ye 2	E				autopsy performed?	prior to completion of cause of
a						1□ Yes 2 🔼	lo 1 Yes 2 No
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death		
of	Phys this al dir	10	XXI es Z IIIO	i □ inpatient 2 □ ErvOutpatien			6 Nother (Specify) at scene
		on:	27. Magner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at 2 Work?	8d. Describe how in	ury occurred
<u>ö</u>	Attanding r death. actor: After by the fune	atl	2 ☐ Accident investigation		M 1 Yes 2 No		
Division	or Attano after death Diractor: in by the	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
	s after al Dira	Certification:		January, Carrier, Capacity,		0.1, 0. 10.11, 0.11	,
	Hospital 24 hours a Funaral I tely filled		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	s) and manner as stated.
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edical	(Check only Medical Exam	iner: On the basis of examination and/or inv and manner stated.	vestigation, in my opinion, death occurre	d at the time, date a	nd place, and due to the cause(s)
	To tha within 2 To the Complet	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
	C > F O		I him hi	m.D	O.C.M.E.	C	tombor 22 2004
						sep.	tember 22, 2004
	7		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, I			Manual and 21201
			31. Date filed (Month, Day, Year)		111 Penn Street, B	altimore,	marytana 21201
***	Sta Regist	ate		32. Registrar's Signature	Sparker.		
	negist	Tell .	SEP 2 4 20	U4 Berner	Life Colors		

		•	1 - State Registrar AMEND ITEM	#20b PER FH (Death		Reg. No	.004	31976
	Physicia	ın	Decedent's Name (First, Middle, Las	st)				2. Date of D	Da	y Year	3. Time of Death
	/Medic	al	MARK 4a. Facility Name (If not institution, give		STARL		or Location of Death			25, 20 County of Deal	
	Examin	er	University Hospit			Baltim		'	40.	. County of Deal	11
	Funeral		Social Security Number 6. So	ex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D	rth ay, Year)	9. Birt	hplace (State or Foreign
	Director		232-13-4280 '	43	Yrs.			4-13-1	1961	W.	Va.
3	and and		10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Many f sh	Ď	Md. Worces	ter 0	cean (ri + v					1 □ Yes 2, No
1	128a	Funeral Director	10e. Street and Number	001	ccuii	10f. Zip Code			10g. Cit	izen of What Co	untry?
1	138 o	D B	10247 Broken So	und Blvd.		218	342			USA	
-	dear ma 3	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N		14. Race - Ame Black, Whit	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. By Injury or other traumatic event, the Madical Examination will be notified at once.	by Fu	1t⊠Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		o i iioaii, etc.,		Specify:	
3	non stura		15. Decedent's Eq		16a. Dece	dent's Usual Occur	pation		16b. K	ind of Business	ite Industry
2	nic in in	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	king			,
7	giene giene	E O	12	College (1-401 5+)	Inte	erior De	esigner		R	etai1	
2 :	al Hys	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	e, Maiden	Sumame)	
3	Menti Menti arked aric e	2	Billie Ray Sta	rliper			June G	lender	ning		
8	and ls mu		19a. Informant's Name/Relationship (**	1		t and Number or Ru				
2 .	and ealth m 27 her tr		June Starliper	Mother			Sound				
5	ges 1 t of H or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑		cemetery, cre	osition (Name of matory or other pla	10/0	172004	20c. L	ocation - City or	Town, State
	tmen tant; jury		`4 □Donation 5 □ Other (Specify	110		on Ceme		10-1-	Ph	illipp	i, W.Va.
ם מ	Depar Depar Impor Impor any in		21. Signature of Funeral Service Licen	nselje /	1	2. Name and Addre	•	T7	_		_
	20.2 e G		23a. Part1. Enter the disease, or com	plications that assess the de-			Tuneral			lin, M	Cl. Approximate
			shock, or heart failure. List only	one cause on each line.	_	11 1 2	1	or respiratory	arrest,		Interval Between Onset and Death
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	o.	rosce	Head 4	-njuries				
	Examiner			Due to (or as a conse	equence of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	1					
	d ansit	Examiner	Cause (Disease or injury								
	execting and and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):	,					
00/00	ficate be executed physicien and is the burial-transit		(d							
0	ortificate be executed ing physicien and e as the burial-transit	Medical									
<u> </u>	8 6 8		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregnanc	ev.			23d. Date of del	
	0 0 D	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)				Month	Day Year
ا	The law requires that the de tte has been signed by the a page 2 should be detached f	Physician/	9 Unknown					00 01			
ń	igned bed	by	Part II. Other significant conditions of	contributing to death but not re	esulting in the t	inderlying cause gi	ven in Part I.			1/	the cause of death?
5	w requir been si should	sted							Yes 2	No 3□Pr	obably 4 ∐Unknown
Records,	elaw hast je 2 s	Completed						24a. Wa	psy	prior to	utopsy findings available completion of cause of
								1 Yes	ormed? 2 □ No	death?	2□ No
VII	iician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea				
0	ohys this al di	7	Yes 2 No 27. Manner of Death	28a. Date of Injury	☐ ER/Outpatie 28b. Time o	III 3 DOA	4 🗆 Nuisilig 🗆	ome 5 Res 28d. Describe		6 □Other (Spe	city)
0	ding I	Certification;	1 □ Natural 5 □ Pending	(Month, Day Year)	Injury	M _M Wo	ork? Yes 2 XNo	1. 1. 3. 1. L	has	i doughou	
DIVISION	r Atten ter deat frector: by the	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At	home, farm, st	7/		28f. Location	(Street ar	nd Number or Ru	ural Route Number,
	in Die g	ert	4 Homicide determined	building, etc. (Spec				Morris Dr	wn, State) Erşelisbu Sbury , M	ry Pevey Philly
	e Hospital 24 hours a e Funeral l letely filled	aic	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my ki	nowledge, deal	th occurred at the t	ime, date and place	, and due to the	cause(s) and manner as	stated.
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 Medical Exar	niner: On the basis of examinand manner stated.	nation and/or ir	ivestigation, in my	opinion, death occu	rred at the time	, date and	d place, and due	to the cause(s)
	To the I within 2 To the I complet	ž	29b. Signature and title of certifier	.1		29c. Licen				te signed (Mont	
			+ample Down	tall, mi		OCM	L		sept	ember 2	6, 2004
, 	1.5		0 1	completed cause of death (Its	ет 23а) (Туре	111 P	enn Stree	et, Balt	imor	e, Mary	land 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Sigistrar's Sig	nature	1 4					
	Regist		31. Date filed (Month, Day, Year) SEP 2 8 2	2004 Bleen	St A	DENE)					

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mai	ryland		rtment of F			, ,	ene	<u>0</u> L	31977
	Physici		Decedent's Name (First, Middle, Las To r	ry Skrivan	ماد	Tr				2. Date of Death Month	Day 26	Year	3. Time of Death
>	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location	of Death	Septemb	4c. County		1921 M
	Examili	er		Revolution			Havre					Harfo	ord
	Funeral		5. Social Security Number 6. S	ex 7. Age		ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Director		219-42-5910	M 2□F 62	2	Yrs.	Months Days	Hours	Min.	(Month, Day,) July 25	,1942		ryland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Loc	ation					14	Od basic Ob it
	daryla f sho	៦	Maryland Har		roo. Ony	, 101111 01 201	Havre	a - C				10	0d. Inside City Limits 1 Yes 2 No
	28a-	Directo	10e. Street and Number	LOIG			10f. Zip Code	de G	race	100	. Citizen of	What Count	
	3a or		100 Revolution St	treet. Apt.	510)		21078		105		J.S.A.	•
	death	Funerai	11. Marital Status	12. Was Decedent Ev			/as Decedent of H Yes, specify Cuba		igin? (Spec	cify Yes or No-	14. Rac	e - America	an Indian,
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			Tes, specify Cuba			tican, etc.)		ck, White, e	etc.
Ö	should be filed within 72 hours after death with the Maryland ud Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Mazical Examiner matic event,	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:							Specif	y: W	hite
7	n 72 I nat	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced (Give)	ent's Usual Occup kind of work done ONOT use retired	ation during mos	st of workin	g 16	b. Kind of B	usiness/Ind	ustry
12	withi	mo D	Elementary/Secondary (0-12) Six Years	College (1-4or 5+))		ounds Ke			1	State	of Ma	ryland
g	filed Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)					_	er's Name	(First, Middle, Ma			-1 y Tana
<u>a</u>	uld be Aental rked o	To B	Jerry Sk	rivanek, S	r.					Dorothy	Woodr	· OW	
ary	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (7	Гуре, Print)		19b. Mailin	Address (Street	and Numb	er or Rural				Code)
Σ.	and 2			son)			terview	Way,	Edgev	vood, Ma	ryland	21	040
ore	Pages 1 nent of Hi int: If Iter iry or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ce	emetery, crem	ition (Name of atory or other place		Da	ate 20	c. Location -	City or Tov	wn, State
	tment tant: tant:		* 4 □ Donation 5 □ Other (Specify	<i>'</i>)	Be1	_	orial Gard		09/30	0/04 B	el Air	, Mar	yland
Ba	permit. Pages Department of Important: If It any injury or o	1	21. Signature of Funeral Service Licen	60	0	Le Le	Name and Addrese A. Pat rryville	ss of Facili	n & S	Son Funer	al Ho	me, P	.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	ne death	Pe Pe	rryville	Mar	yland	1 2190;	<u>3-0766</u>		Approximate
	Contilicate be executed American and India physician and India sas the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a control or	Consequ	elice vij.			(AKV	(BC 1N)	H4XC7	non_	Onset and Death
ă.	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetel	death 3 🗌	Ectopic pregnancy Other <i>(specify)</i>	,			23d. Dat	te of deliver	y Day Year
S,	g	by Pr	Part II. Other significant conditions of	ontributing to death but	not resu	Iting in the un	derlying cause give	en in Part I		23e. Did tobac	co use cont	ribute to the	e cause of death?
ğ	w requires been sign should be	edt	-0AD							1 ☐ Yes	2 🗆 No	3 ☐ Proba	abiy 4 Munknown
Vital Record	e law requ has been je 2 shoul	Completed	- DM							24a. Was an	24b. \	Were autop:	sy findings available ipletion of cause of
Ĕ	The te h	ĕ	,							autopsy performe	d? (death?	ipletion of cause of
Ħ.	siclan: certifica rector, p	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only one)			
6	Physis this o	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient		ER/Outpatient		4 🗀 NU	ırsing Hom	e 5 🖾 Residenc	e 6 □Oth	er (Specify)	
ב	ding F	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear)	28b. Time of Injury	28c. Injun Worl			3d. Describe how	injury occurr	red	
Division	tten deati deati	icat	2 Accident investigation 3 Suicide 6 Could not be		r - At hor	me form etre		Yes 2□	_	of Leastian (Ctm)	a a mad & tram b	C (C
=	를 를 드	Certification:	4 ☐ Homicide determined	building, etc.	(Specify))	et, ractory, onice		28	3f. Location (Stree City or Town, S	state)	er or Hurai.	Houle Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edicai C	29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam	ysician: To the best of hiner: On the basis of each manner state	xamınatı	vledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date an pinion, dea	d place, ar th occurred	nd due to the caus d at the time, date	e(s) and ma and place, a	inner as sta and due to t	ted. the cause(s)
	To the within 2 To the complet	Š	29b. Signature and title dertifier	1	-/	^	29c. License	e number		29d	Date signed	(Month D	ay, Year)
			/ framas	X. Blan	de	(NN)	1)4	280	0		9/28/	04	
	8		30. Name and address of person who	completed cause of dea 3/4 32. Pigistrar's	th (Item	23a) (Type, F	rint)	4. /	40/6	Mars :	21078	/	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 7 2	004 32. Prigistrar's	s Signati	b A	orte			/			

			1 - State Registrar	ate of Marylan	d / Depa		lealth and	, ,	ene	31070
			Decedent's Name (First, Middle, Last)	· · ·		incate or	Dealit	2. Date of Death	g. No, UU	3. Time of Death
	Physicia			C to a 1				Month	Day Year	
	/Medic Examin		Nora Kathryn 4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of De		er 24, 200	
	Examin	er	Shady Grove Adventis			Rockvi				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H		Montgome 9. Bi	rthplace (State or Foreign country)
	Director		217-80-3575	² ☑ F 76	Yrs.	Months Days	Hours M		1928 Vi	
	2		Usual Residence of Decedent					Train 30	1720	griita
	arylar show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Ba-f.	cto	Maryland Montgomery	R	ockvil	<u>le</u>				1 Yes 2 No
	within 72 hours after death with the Maryland ene. then "neturel", or tems 23a or 28a-f show the Medical Examinan mast be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	ath v		299 Hurley Avenue			20850			U.S.A.	
	er de	Funerai	Ar	as Decedent Ever in U. med Forces?	S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
50	s aft	by F	If	∏Yes 2 X No Yes, Give ear or Dates:		□Yes 2¶ No	Specify:		Specify:	
2-003p	hour fure	edt	15. Decedent's Education		16a Decer	lent's Usual Occup	ation	1	Sb. Kind of Business	nite
Ò	in 72 in 6	Completed	(Specify only highest grade com	pleted)	(Give	kind of work done	durina most of v	vorking	ob. Kind of Business	windustry
717	with iene.	E O	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		omemaker	•		Own Home	
	Hyg Hyg other ent,	a)	17. Father's Name (First, Middle, Last)			Omemaker	18. Mother's N	lame (First, Middle, M		
yıand	id be ental ked o	To B	Garland R. Mann,	Sr.			Hild:	a E. Fawl	ev	•
	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, ILE M.	-	19a. Informant's Name/Relationship (Type, Pr		19b. Mailin	g Address (Street		Rural Route Number,		Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Healith and Mental Hygiene. A filed the marked other then "neturel", or Items 23a or 28a-f show teems 1 s marked other then "neturel", or Items 23a or 28a-f show other traumatic event, if a Moulest Examiner must be notified at		Roy L. Stanley - Son	ı	11424	Meadowla	ark Driv	e, Ijamsv	ville, Mai	yland 21754
ā,	os 1 and 3 of Health item 27 other tra		20a. Method of Disposition	20b. P	.1	sition (Name of natory or other place			Oc. Location - City o	
Бащтоге	permit. Pages 1 Department of F Importent: If ite eny injury or ot once.		1 ☑ Berial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Denation 5 ☐ Other (Specify)			Cemetery		28/04 Da	mascus, M	[arvland
	artm artm orter injur		21. Signature of Fulleral Service Licensee							
ñ	Dep imp eny		Forest d. Med	leams	0.	Lin L. Mo	leswort	h P.A., Fu	neral Hom	ie
			23a. Part1. Enter the disease, or complication	ns that caused the death	n. Do not ente	o4UL Klag or the mode of dyin	ge_Road, ig, such as card	Damascus iac or respiratory arres	, Marylan	d 20872 Approximate
	Thusialan		Immediate Cause (Final	ise on each line.						Onset and Death
	Physician /Medical		disease or condition resulting in death) a	Due to (or as a consequence)	515					16 hours
	Examiner				uliti					1 week
l.	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq		<u></u>				
	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury							
'n.	be executed ician and burial-transit	Examiner		Due to (or as a consequence	uence of):					
8/60,	ate be executed hysician and the burial-transit	ical	d							
ğ	death certificate e attending phys id for use as the									
ŏ	leath certifica attending phy I for use as th	N/I		yes, outcome of pregna □Live birth 2 □Fetal		Nataria			23d. Date of de	livery
		icia	1 Yes 2 No	Pregnant at time of d		Ectopic pregnancy Other (s <i>pecify</i>)			Month	Day Year
j.	at the by th tache	Physician/Med	9 □ Unknown	Unknown						
, S	law requires that the de as been signed by the 2 should be detached	ру Р	Part II. Other significant conditions contribut			ndertying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
cords,	equire en siç ould b	ed	congestive her	art ta	elure			1 ☐ Yes	2. No 3 □ P	robably 4 Unknown
ဝင္	aw re is bea	Completed	•					24a. Was an	24b. Were a	utopsy findings available
ř	The I	E O						autopsy performe	death?	completion of cause of
Vital		O	25. Was case referred to medical				26. Place of D	1 ☐ Yes 2. eath (Check only one)		2 No
>	Physiclen: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospita	al: 12 Inpatient 2	ER/Outpatien	t 3□ DOA Oth		Home 5 ☐ Residen		ecify)
וסר	ding Ph h. After th funeral		27. Manner of Death 28:	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injun Worl	y at	28d. Describe how	injury occurred	,,
0	Attendin death. ctor: Af y the fur	atic	2 Accident investigation	(monin, buy rour)	iii)di y		Yes 2 □ No			
UIVISION	er de recto	tific	3 Suicide 6 Could not be determined 286	e. Place of Injury - At he building, etc. (Specifi	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
5	tel or	Certification:						0.0, 0 0,	oraro,	
	hour hour ner		29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: Constitution of the constitution of	To the best of my kno	wledge, death	occurred at the tin	ne, date and pla	ce, and due to the cau	se(s) and manner a	s stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	Medical	a.	nd manner stated.	non and/or inv					
	with To	2	29b. Signature and title of certifier	monthe	MI	29c. License		290	f. Date signed (Mon	,
			> Upusto L	gove	1111	6	1549		9/24/	12004
	4		30. Name and address of person who complet							
		ej c	Christine Lepout			ical Cen	ter Dri	ve, Rockvi	lle, Mary	land 20850
	Sta Registr		SEP 2 7 2004	32. Registrar's Signa	ture &	lan.				

DHMH 17 Rev 1/2001

		4	_ State	State of Mary	•	artment of H			giene Reg. No.	0.01	210	~7.0
			Registrar 1. Decedent's Name (First, Middle, Last)			tinoato or i		2. Date of De	ath	UU4	3. Time of	f Death
	Physici /Medic		EVELYN BETTY	STOVER				Sept	25 Day	2004 ^{ear}	1:00	A M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deat	h	4c. C	ounty of Death		
			Northampton Manor N			Frederic				ederic		
	Funeral Director		5. Social Security Number 218−30−2793 6. Sex 1□	M 2 TXF 7. Age (Ir	yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	Hours Min.		ıy, Year)	9. Birth Cou	place (State on intry) ryland	or Foreign
	p .		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo	antion					10d. Inside C	
	Aaryla I sho	ō	Maryland Frederic		Frederi					į		2 X No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?	
	h with	D	200 E. 16th Street			21701			Unite	d State	es	
	ems 2	Funeral	11. Marital Status	2. Was Decedent Eve Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	specify Yes or No	o- 14	. Race - Ameri Black, White		
36	d within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show tre Medical Evaninal must be redified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【※*Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	, 5.6.,	s		hite	
9-0	72 hou	ted	15. Decedent's Educ	ation	16a. Dece	ient's Usual Docupa	ation		16b. Kind	of Business/Ir	ndustry	
215	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired)	rking				
121	filed within Hygiene. other than rent, tre M		17. Father's Name (First, Middle, Last)		Hai	r dresser		(F' 14'- - -		r dress	sing	
land	o d a b	To Be	Raymond M. Burns				18. Mother's Nar Thelma		, Maiden Si	umame)		
Maryland 21215-0036	C1 (0 0)	-	19a. Informant's Name/Relationship (Type Mary Lynn Zwilsky		19b. Mailir 3516	ng Address (Street a	and Number or Ru untain R	ural Route Numb	er, City or 1	Town, State, Zi,	p Code)	21758
Baltimore,	ges 1 and 2 t of Health if item 27 or other tree		20a. Method of Disposition 1 ☐ Burns 2 [X]Cremation 3 ☐ Re	amoval from State	-	natory or other plac		Date 27,		ation - City or T		
Itim	it. Pa rtmen rtent: njury	li	* 4 □ Donation 3 □ Other (Specify) 21. Signa ure of Funeral Service Licen	_		tan Crema		2004		andria,		lnia
Bal	permit. Pages: Department of H Importent: if ite any injury or ot		Torest 2 -	Tilliam		Olin L. M 26401 Rid	oleswort ge Road,	h, P.A. Damasc	Fune: us, M	ral Hom aryland	ie 20872	2
П			23a. Part1. Enlocthe disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approxima Interval Bei Onset and	tween
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Myo	cardial	Infaro	from				Minn	4
	/Medical Examiner		resulting in death,	Due to (or is a co	onsequence of):	1 /	Failure				17-	
	1	ē	Sequentially list conditions, b	Due to (or 45 a co	onsequence of):	HEAV'T	railme				year	1
	cuted nd ransit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	0								
, 00	sician and burial-transit	Ex	resulting in death) Last	Due to (or as a co	onsequence of):							
8760,	ate b	dicai	d							-		
9	eath certific attending p I for use as	/Me	IF FEMALE:	3c. If yes, outcome of p	pregnancy				00	d. Date of deliv		
Вох	atten afor u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 □ 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23	Month		Year
o.	at the de by the	hysi	9 Unknown	9□ Unknown								
ds, P	ires tha signed d be de	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		tobacco use Yes 2 🗆	ocontribute to		death? Unknown
cor	w requ	iete						24a. Was	an	24b. Were aut	opsy findings	available
I Records,		Completed						auto	osy ormed?	prior to co death? 1 🗌 Yes	ompletion of c	cause of
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			la.		ath (Check only	опе)			
of \	this al dir	2	1 ☐ Yes 2 No	ospital:	2 ER/Outpatier		4 Nursing F	lome 5 ☐ Res			ify)	
		tion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) Injury	Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred		
Division		Certification:	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st					Number or Rur	al Route Nun	nber,
D	el or At s after d el Direct ed in by	Cert	4 Homicide determined	building, etc. (Specify)			City or To	wn, State)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month	Day, Year)	
			1			Dy	3091		9-3	27-04		
	I		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print) TOLL	Hous	e Arle	Fre	denck	MI)
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 7	32. Registrar's	Signature	& So	e number 3091 Hous				1	

		1	= For 9-30-04 Registrar Amend #18.Per	State of Marylan	0	artment of H tificate of I			ene g. No:	4 31980
	siciar	1	1. Decedent's Name (First, Middle, Last) Gladys Antonia Si		<u></u>			2. Date of Death Month	Day Y	3. Time of Death 2004 7:10 AM M
ž	edica mine	_	a. Facility Name (If not institution, give s 5006 N. Englewood	·			r Location of Death Heights	Septem	4c. County of	
Fune Direc			5. Social Security Number 6. Sex		last birthday) Yrs.	tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 16	Year) 1930 I	9. Birthplace (State or Foreign Country) Ominican
Maryland			10a. State 10b. County Maryland Prince (Georges 10c. Cit	y, Town or Lo apitol	Heights				Republic 10d. Inside City Limits 1 \(\overline{\pi} \) Yes 2 \(\overline{\pi} \) No
th with the		runeral Director	10e. Street and Number 5006 N. Englewood	Drive		10f. Zip Code 20743		10	g. Citizen of Wh	at Country?
5-0036 72 hours after death with the Maryland natural; or Itams 23a or 28a-1 ehow		2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I Yes 2□ No	lispanic Origin? (Spea an, Mexican, Puerto F Specify: Domin			American Indian, White, etc. Black
21215-0036 sd within 72 hours aff gjene. or than "natural", or		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done of DO NOT use retired ewife	ation during most of workin d)	g	6b. Kind of Busi Own	ness/Industry Home
Maryland and and a should be filed the and Mental Hyger 127 is merked others.	The available	lo Be C	17. Father's Name (First, Middle, Last) Rafael Fernandez				18. Mother's Name - Cladys			Fabian
and 2 shored to a street of the street of th			19a. Informant's Name/Relationship (Type Dora Alicia Deegbo		19b. Mailin	g Address (Street Pooks Hi	and Number or Rural	Route Number, Sethesda	City or Town, St Md 2081	ate, Zip Code) 14
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked onliver than "natural", or items 23a or 28a-f ehow	ODCE.	Ì	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify) 21. Size Ture in neral Service License	emoval from State Geo	emetery, crem orge Wa dical (. Name and Addre	Universepte	mber 23	2004 V	ity or Town, State Wasington DC Box 58007
Physici /Medic	ian cal		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line. Bladd Due to (or as a consequence)	h. Do not ente	Washingto er the mode of dyin	n DC 2003	7 respiratory arres		Approximate Interval Between Onset and Death
68760, ficate be executed physician and	lar-transin	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
O. Box 6 the death certify the attending	ď .	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy	,		23d. Date of Month	-
cords, P. wrequires that been signed by		2	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			ute to the cause of death?
The law	bage 2	Completed						24a. Was an autopsy perform	ed? pric	ore autopsy findings available or to completion of cause of ath?
Phy Phy	all direct	0	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2	ER/Outpatien 28b. Time of Injury	28c. Injun Wor	y at 2	100	ce 6 Other	
Division tal or Attending at Director. After	n fa ui pà n	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office	2	8f. Location (Stre City or Town,		or Rural Route Number,
To the Hospital within 24 hours a To the Funeral	oletely till	ledical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ition and/or inv	estigation, in my o	pinion, death occurre	d at the time, dat	e and place, and	d due to the cause(s)
Town	, , , , , , , , , , , , , , , , , , ,	M	29b. Signature and title of certifier	wellen M.	D	29c. Licens	2697 Z	-MD 9	d. Date signed (Month, Day, Year)
CH(8)	Clark	2	11. 7 = 1	impleted cause of death (Iter 2. Registrar's Signa	n 23a) (Type,	6525	Beleved	ffd.	tyatts	willend
Re	Stat gistra ev 1/200	r	SEP 2 7 2004	Jeron &	Apar	R.			/	2702

		1 - State Registrar 1. Decedent's Name (First, Middle, Las.)			Departme Certifica				, ,	Reg. No. [] [14 31981
Physic		1. Decedent's Ivanie (1 iist, Middle, Lasi	Zachary	Leroy	Summer	s			Septemb	Day	Year 2004 7:37 M
/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of		-CPICINE	4c. County	2000
		Washington County				lagers				Was	hington
Funeral		5. Social Security Number 6. Security Number 11	9x 7. Age Mg 2□F	(In yrs. last b	Yrs. If Und Month	ler 1 Year s Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day	h v, Year)	Birthplace (State or Foreig Country)
Director		Usual Residence of Decedent	,.	70	113.	<u></u>			Jan. 29	1934	Maryland
nyland how		10a. State 10b. County		10c. City, Tox	wn or Location						10d. Inside City Limits
Be-1 s	ctor	Penna. Frankli	in	Gree	encastle	2					1 ☐ Yes 2 🔏 No
with the	Dire	10e. Street and Number			10f. 2	Zip Code				10g. Citizen of \	What Country?
eath v	Funeral Director	5212 Bino Rd.	12. Was Decedent E	ver in IIS	13 Was Doo	17225		in? /Cnoo	ify Yes or No-	U.S.	• A •
r item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X N		If Yes, sp	ecify Cuba	n, Mexican,	Puerto R	ican, etc.)	Blac	ck, White, etc.
72 hours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2 No	Specify:			Specify	y: White
if it is 15-15-15-15-15-15-15-15-15-15-15-15-15-1	Completed	15. Decedent's Edi (Specify only highest grad		168	a. Decedent's Us (Give kind of v life. DO NOT	ual Occupa	ation during most	of working	9	16b. Kind of B	usiness/Industry
within ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Welde		")			Door (Co
e filed within all Hygiene.	0	17. Father's Name (First, Middle, Last)					18. Mother	's Name ((First, Middle,	Maiden Suman	
yland buld be fill Mental Hy arked oth atic even	To B	Simon Su	ummers				Wi	nnie	Rideno	our	
and and is m		19a. Informant's Name/Relationship (T		19							State, Zip Code)
C, E		Lucille E. Summer	rs/Wife	20h Place	5212 Bi		. Gre	encas Da		Pa. 1722	
Peges 1 e ment of Hee ant: if Item ury or othe		1 Burial 2 □ Cremation 3 □		cemete	ery, crematory of	r other plac			30/04		Castle, Pa.
Deficiency Department of popularity if it in in injury or o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Taccuc			s of Facility		30704	oreend	cascie, la.
Demit. Depertrimports any inju		H. Martini Zen	men.	5~.	Zimme	rman	And So	on Fi	ineral	Home Ir	nc. Pa. 17225
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused one cause on each lin	the death. Do	not enter the m	ode of dying	g, such as c	ardiac or	respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	FALO ST	- /							Onset and Death
/Medical			a ~~0 0 1	محر ر	we di	secs	re o	ve f	U Hor	etitis (10 + UPAIS
Examiner		resulting in death)			ive Vi	secs	se o	ve f	v Hyn	etitis (C 10+years
	er		. Erephis			sees	se o	ve f	v Hyn	etitis (Ulawa
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Erephis	e MA		secs	ce o	ve f	v Hyn	etitis (C 10+years w/awn
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OI VITAL NECOLUS, F.O. DOX 00100, F.O. Physician: The law requires that the death certificate be executed in this certificate has been signed by the attending physicien and stall director, page 2 should be deteched for use as the buriat-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditio	b. Due to (or as a d. Due to (or	a consequence a consequence of pregnancy 2 Fetal death at not resulting	e of): h 3 Ectopic 5 Other (in the underlying	pregnancy specify) g cause give	en in Part I. 26. Place c er: 4 □ Nurs	of Death (23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes 'Check anly or	23d. Dai Mo	te of delivery onth Day Year tribute to the cause of death? 3 Probably 4 Junknowr Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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or Attending Physician: The law requires that the death certificate be executed filer death. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be deteched for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due birth 4 Pregnant at 9 Unknown contributing to death but the de	a consequence a consequence a consequence a consequence a consequence before pregnancy befo	a of): the 3 Ectopic 5 Other (in the underlying of Injury M farm, street, factor of Injury M	pregnancy specify) g cause give DOA Othe 28c. Injury Work 1 1	26. Place cer: 4 □ Nurs / at /? Yes 2 □ No	of Death (sing Home) 28 lo 28	23e. Did to 1 Y: 24a. Was a autops perfor 1 Yes **Check anly or e 5 Resided. Describe head of the control	23d. Dai Mo an State) an State) an State) an State)	te of delivery onth Day Year tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Ner (Specify) red
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. 2 () () ()	31982
• Physician		2. Dete of Deeth Month Day Year Sep 27, 2004	3. Time of Death
/Medica Examine	A = 30 Al		1:00 pm
Examine	Cumberland Nursing Center Cumberland	Allegany	••
Funeral Director	5. Social Security Number 218-30-2379 6. Sex 1 M 2 XF 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		hplace (Stete or Foreignotty)
and war	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
vith the Maryl t or 28e-f sho	145		1 XYes 2 □ N
ter death with the Marylan flems 23s or 28s4 show the must be notified at the mare.	106. Street end Number 135 N. Mechanic Street Apt 1105 21502	10g. Citizen of What Co USA	
urs af	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	ify Yes or No- lican, etc.) 14. Race - Ame Black, White Specify: Wh	e, etc.
ed within 72 horygiane.	15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/I	Industry
ed with rgiane or the	Elementery/Secondary (0-12) College (1-4or 5+) Laborer	Footers Dye	Works
should be fill and Mantel Himerked oth urrette even	17. Fether's Name (First, Middle, Last)	(First, Middle, Maiden Sumame) B. Marker Short	
and 2 sho latth and 1 27 Is me er traume	19a. Informant's Name/Relationship (Type, Print) Phyllis Hare niece 19b. Mailing Address (Street and Number or Rurel II 1100 S. Belcher Rd	Route Number, City or Town, State, Z Largo F	
Peges 1 ment of Ha ant: if Item ury or oth	1 Xurial 2 Cramation 2 Demoval from State cemetery, crematory or other place)	Date 20c. Location - City or 7 0/1/2004 Fort Ashby	
permit. Departm Importar any inju	21. Signature of Funera/Service Licensee Scarpelli Funeral Hor 108 Virginia Avenue:	me, PA Cumberland, MD 2150)2
Physician Medical Examiner	23a. Part 1. Enter the disease of comblications that caused the death. Do not enter the mode of dying, such as cardiac or or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or and consequence of):	1	Approximate Interval Between Onset and Death
eath certificets be axecuted ettending physicien end for use es the burial-transit clan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):		
death e etten ed for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22h Did tehana was anti-hut-	
requiras that tha death ce een signed by the ettend hould be datached for us		23b. Did tobacco use contribute 1 Yes 2 No 3 Pro	obably 4 Unkno
S S S		performed? a	Vere autopsy findings vailable prior to completion of cause of death?
E ag a 2		1 Yes 2 No 1	☐ Yes 2☐ No
delan: The certificata rector, pag	25. Was case referred to medical examiner? 1. Type 2. Type 2. Type 3.		
	1 inpatient 2 EH/Outpatient 3 DOA 3 Invising Home	e 5 ☐ Residence 6 ☐ Other (Special Describe how injury occurred	ify)
tal or Attending P rs after deeth. al Director: Aftar t led in by tha funara Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rui City or Town, State)	ral Route Number,
To the Hospital within 24 hours a To the Funeral I complately filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the complex of the death occurred at the time, date and place, and the complex of the death occurred and manner stated.	d due to the cause(s) and manner as at the time, date and place, and due	stated. to the cause(s)
within To the Comp	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month	*
	1) 0033280	Sept 29,	2004
3	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 625 kent Ave	Sept 29, 3 Camberlad on	021501
State Registrar	31. Dete filed (Month, Dey, Year) 32. Registrer's Signature Area & Are		

		1 - State Amend Item	State of M 10e&19b pe	aryland / Dep er informat	partment of F Triffcate of	lealth and Death 4	Mental Hygiei t as	004	31983
Physic	ian	Decedent's Name (First, Middle, L	ast)	0	1		2. Date of Death Sep 28, 20	Day Yea	3. Time of Death
/Medi	cal	Joseph +	ive street and number	Sangiova		r Location of Dea		4c. County of De	
Exami	ner	Allegany County N	lursing Hor	ne	Cumberl	and	P	Allegany	
Funeral Director		5. Social Security Number 6. 217-10-4018 Usual Residence of Decedent	Sex 7. Ac	ge (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs Hours Min		9 17 N	Birthplace (State or Foreig
d 21213-UU36 filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or itams 23a or 28a-f show int, the Medical Examinar must be notified at	tor	10a. State 10b. County MD Allega	ny	10c. City, Town or L	ocation berland				10d. Inside City Limits 1 Yes 2 No.
with the	Direc		Carns Avenu	ie	10f. Zip Code	21502	10g.	Citizen of What	Country?
eath v	erai	4211 Karns Avenu	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H		Specific Ves or No	,	merican Indian,
JSD urs after d II', or itam	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2 KYes, Give Year or Dates:	No No	If Yes, specify Cuba	Specify:	rto Rican, etc.)	Black, W	hite, etc.
2 hou	ted	15. Decedent's I		16a. Deci	edent's Usual Occup	ation	16b	. Kind of Busines	
Aghin 7	mple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done of DO NOT use retired	1)		of Cum	shorland
Hygier ther th		12 17. Father's Name (First, Middle, Las	(st)	Street	Departme		me (First, Middle, Maid	y of Cum	iberiano
Maryland 21213-5-0035 nd 2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked other than "natural", or rtraumatic event, the Medical Exemi	To Be	John Sangiovai	nni	,		Caloge	ra Cannistr	ato San	
hy Mar and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship Mildred Sangiova		19b. Mail . 121	ing Address (Street 1 Karns Av Karns Av	and Number or R /CNUC C CNUC	ural Route Number, Cit Cumberl	y or Town, State and	MD 21502
PS 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1		20a. Method of Disposition 1 (XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				xe)	}	Location - City o	
Baltimo permit. Page Department of important: If any injury of once.		21. Signature of Funeral Service Lice	J. Acar	2002	2. Name and Address Scarpell		lome, P.A. le; Cumberland	d MD 215	02
by (bu), we iterate be executed by hysician and burial-transit site burial-transit	edical Examiner	23a. Part1. Enter the disease, or bot shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CNO Due to (or as b. Due to (or as c.	a consequence of): a consequence of): a consequence of):			DISEASE	-	Approximate Interval Between Onset and Death 2 4 R S
UNISION OI VITAI NECOLAS, P.O. DOX OF To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy			23d. Date of d Month	lelivery Day Year
quires that	by	Part II. Other significant conditions	contributing to death b	out not resulting in the I	underlying cause give	en in Part I.	23e. Did tobacci		to the cause of death? Probably 4 □Unknown
The law requires to the law sequires to the law been signed page 2 should be to the law	Completed					-	24a. Was an autopsy performed?	prior to	autopsy findings available completion of cause of
cian: ertific actor,	Be (25. Was case referred to medical examiner?					ath (Check only one)		
hysia this c	ပ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie			4 Nursing I	tome 5 Residence		pecify)
UNISION OF VIGAL IN- t or Attending Physician: The latter death. Director: After this certificate ha din by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	he	y Year) Injury	M 1	vat <br Yes 2 □ No	28d. Describe how in		
To the Hospital or Attenwithin 24 hours after deat To the Funaral Director: completely filled in by the		4 Homicide determined	building, et	ury - At home, farm, st c. (Specify)			28f. Location (Street City or Town, Sta	ite)	
To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier 1	hysician: To the best miner: On the basis of and manner st	f examination and/or in	th occurred at the tim	ne, date and place pinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner a nd place, and di	as stated. ue to the cause(s)
To t withi To th	×	29b. Signature and title of certifier	1. Bu	nera l	29c. License	1486		Pr. 30	114, 2004
ì		30. Name and address of person who	completed cause of o						1
St	ate	Robustiano Bari	rera M.D.	Men	n. Hosp Me	ed Bldg C	umberland	MD 2150)2

DHMH 17 Rev 1/2001

Registrar

OCT 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month q **Physician** Mal 04 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomia Salisbur **Ancho** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 252 F 82 219-34-3237 Yrs. Director 06/06/1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic event, the Michael Examiner man be rotified at 1 ☐ Yes 2 € No Director Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 28252 Waller Road Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 □Yes 2⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 16 Schoolteacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Ellis Nora Waller Ellis ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce T. Hovatter/daughter 28261 Waller Road Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or Laurel Hill Cemetery 109/24/04 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 13 E. Grove Street Short Funeral Home Delmar, DE que 23a. Part1. Exter the disease, or composhock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** HSUND 4 cous /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last ng physician ar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown should should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page certificate or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၀ 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending within 24 hours aner use.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) vola Nala DR'USHA NATESAN D057359 September 23 42004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

SAUSBURY

32. Registrar's Signature

1415. S. DIVISION ST

SEP 2 3 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** THOMPSON Month Year THELMA 2325 M SEPTEMBER 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** SEPTEMBER 27,1945 MARYLAND 1 ☐ M 2 🌠 F Director 58 Yrs 215-46-3794 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-1 show 10d, Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director MARYLAND CHARLES INDIAN HEAD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3304 ANTON COURT 20640 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE DOMESTIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MITCHELL MARSHALL FLORENCE WOOD ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum <u>once.</u> 3304 ANTON COURT, INDIAN HEAD, MARYLAND JAMES CLIFF MARSHALL / SON 20a. Method of Disposition
1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) TRINITY MEMORIAL GARDENS 9/29/2004 WALDORF, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic. n. de THURNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON JOHNSON MOO583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CONGESTIVE HEART FAILURE 30 MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cidus. mul MD RES- 000 SEPTEMBER 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADNAN MALIK, JOHNS HOPKINS HOSPITAL, TOWER 110, DOCTORS LOUNGE, 600 NORTH LYOLFE STREET, 31. Date filed (Month, Day, Year) 32. Registrar's Signature BALTIMORE, MARYLAND 21287 State SEP 2 4 2004 Registrar

		4	partment of Health and Mertificate of Death	flental Hygiene	
Physic		1. Decedent's Name (First, Middle, Last) Julia D. Valentine		2. Date of Death Month September 21 2004	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give street and number) 2804 John Thompson Road	4b. City, Town, or Location of Death Temple Hills	4c. County of Death	
Funera Directo		5. Social Security Number 577-42-2788 6. Sex 1 M 2 F 7. Age (In yrs. last birthda, 74 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Sep. 18, 1930 8. Date of Birth (Month, Day, Year) Sep. 18, 1930 Wa	pplace (State or Foreign intry) ash., DC
ore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event. The Medical Exam has must be rediffed at	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or	Capitol Heights 10f. Zip Code 20743 3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: Redent's Usual Occupation re kind of work done during most of work DO NOT use retired) U.S. Postal Servi 18. Mother's Name	Rican, etc.) Black, White All Specify: An 16b. Kind of Business/I	States ican Indian, Prican nerican ndustry nent
Baltimore, permit. Pages 1 a Department of Hea Important: If them any injury or othe		'4 □ Donation 5 □ Other (Specify) George Wa	ashington Cem. 9/25 22. Name and Address of Facility 2 4001 Benning Rd.,	5/2004 Adelph Stewart Funeral Hom , N.E. Wash., DC 20	ni, MD ne 0019
Ox 68760, n certificate be executed Examine physician and one as the burial-transit	1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death
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	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
I Re The la ate has page 2	e Completed	25. Was case referred to medical	26. Place of Death	autopsy performed? death? 1 □ Yes 2 No 1 □ Yes	opsy findings available ompletion of cause of
on of ding Phy h. After this funeral d	Certification; To B	examiner? 1	ent 3 DOA Other: 4 Nursing Hol of 28c. Injury at Work? M 1 Yes 2 No	me 5 ☐ Residence 6 X Other (Speci 28d. Describe how injury occurred 28f. Location (Street and Number or Run City or Town, State)	· ·
Division To the Hospital or Attention Within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) and manner as red at the time, date and place, and due to	stated. o the cause(s)
To the lawithin 2. To the law complete	×	29b. Signature and title of certifier hebitia of Caule My	29c. License number	29d. Date signed (Month,	
CR (7) S Regis	tate trar	30. Name and address of person who completed cause of death (Item 23a) (Type Letita G. Carlson Mp Gwo) MF 31. Date filed (Month, Day, Year) SFP 2 7 2004		1. Ar, NW Wash	1-5t2,020037

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day
September 22, Physician Helen Frances Welty 2004 11:14AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 □ M 2 🗓 F Yrs Director 053-26-3229 72 August 11, 1932 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or Itams 23a or 28e-f ahow other traumatic avant. The Modical Examiner must be notified at 10d. Inside City Limits 1 □Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5916 Johnson Avenue 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ified within 72 hours after de l'Hygiene. Othar than "natural", or Itam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse/Owner Nursing/Day Care Center ges 1 and 2 should be filed v t of Health and Mental Hygie If itam 27 is marked othar t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Job R. Renick 0 Louise Trimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl G. Welty/Husband 5916 Johnson Avenue, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
any injury or ott Gate of Heaven Cemetery or other place) September injury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 27, 2004 Silver Spring, MD 21. Signature Truneral Service Linear ee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Aspiration Pneumonia disease or condition resulting in death) 5 Davs /Medical Due to (or as a consequence of): **Examiner** Amyotrophic Lateral Sclerosis 10 Months Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy į in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. the Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Colon Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 2XXNo 1 🗌 Yes 2 No Division of Vital 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending within 24 hours after death. To tha Funaral Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061631 September 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chen, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State rocks SEP 24 2004 Registrar

			1 - For State Registrar	State of Marylan	d / Depa	artment of H	ealth and i	Mental Hy	9	Jie.	3 96	3 8
I	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	Year	3. Time of [Death
,	/Medi	cal	DWIGHT		N			Sept	1	004	2:00	A M
	Examir	ier	4a. Facility Name (If not institution, give : Manor Care of		2	4b. City, Town, or			4c. County			
	Funeral		5. Social Security Number 6. Sex	x 7. Age (In yrs. I		Silver If Under 1 Year	Sprin If Under 24 Hrs.	8. Date of Birt	Monto			r Foreian
L	Director		577-72-4228	^{M 2□F} 50	Yrs.	Months Days	Hours Min.	(Month, Da	0, 1954	Was	lace (State or atry) Sh. D(C
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	ocation			7 - 5 - 1			
	Aaryla r sho	5		Georges		Upper Ma	rlhoro			10	0d. Inside City 1 ☑ Yes	•
	the 128a-	rect	10e. Street and Number	George		10f. Zip Code	11 10010		10g. Cîtizen of W	Ihat Coun		
	n with	Funeral Director	10236 Prince	Place, T-4			20774		_	S.A		
	death	ner		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (S	pecify Yes or No	14. Race	- Americ	an Indian,	
36	or Ita	y Fu	1 Never Married 20 Married	1 ☐ Yes 2 No If Yes, Give		1 □ Yes 2 😾 No	Specify:	o mican, etc.)		k, White, e		
Ö	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dical Examiner must be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:			•			Bla		
15	in 72 nan 'n	Completed	15. Decedent's Edui (Specify only highest grade	e completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired;	tion uring most of wor	king	16b. Kind of Bu		,	
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פר	e file al Hyg otha	BeC	17. Father's Name (First, Middle, Last)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's Nam	ne (First, Middle,			Ouse	
<u> a</u>	Ments Ments arked	2	James E. W	ilson				yel La				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any njurg porther traumetic evant, it s Marical Examiner must be nutitive at once.		19a. Informant's Name/Relationship (Ty)	, and the second	19b. Mailir	ng Address (Street a	nd Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code 207	74
e,	1 and dealth am 27 thar t		Thalia Wilson (1023	6 Princ	e Pl. #	T4, Up	per Ma:	rlbo	ro, M	ĺD
Baltimore,	10 = 10 mg/s		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P			sition (Name of matory or other place		Date	20c. Location - 0	-		
臣	urtmer priant njury		4 □ Dogation 5 □ Other (Specify) 21. Signature of Funeral Service License	Ga	te of	Heaven	Cem 9/	27/04	Silve	r Sp	ring,	MD
Ba	Deperment of the permet of the permet of th		VANA K.X	110000	11/2	Name and Address	ash St	ROC	FUNERA.	MD.	ME, P	.A.
			23a. Part1. Enter the disease, or compli	cations that caused the death	-							
	Physician		Immediate Cause Final	Metastat				•			Approximate Interval Betwee Onset and De	een eath
	/Medical		disease or conditi®n resulting in death)	Due to (or as a consequ		ing bise	15 e				-	
П	Examiner		Sequentially list conditions	Carcinom	a of	Larynx						
	Sit ad	iner	Sequentially list conditions, in the latest of the cause. Enter Underlying Cause (Disease or injury	Due to for as a consequ	anna of):							
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ones of):							
8760,	be exician buria			ode to (or as a consequ	ierice cr).							
687	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical										
Вох	that the death certific ed by the attending p detached for use as	W/U	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar					23d. Date	of deliver	rv	
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)	···		Mon		Day Ye	ar
P.O.	at the by th	hys	9 🗆 Unknown	9□ Unknown								
	res tha iigned be det	by F	Part II. Other significant conditions con			nderlying cause give	n in Part I.	23e. Did to	bacco use contri	oute to the	ause of dea	ath?
ord	w requir been si should	ted	Pneumonia,	Malnutritio	n			X □ Y	es 2□No :	∃ □ Proba	ibly 4 □Un	iknown
Vital Records,	e taw has b	Completed	Failure to	Thrive, Emp	ysema			24a. Was a autops	sy pr	ior to com	sy findings av	
E H								perfor 1 ☐ Yes		eath? Yes 2	2□No	
<u> </u>	Attanding Physician: The rideath. actor: After this certificate hiby the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:		Other	26. Place of Deat				*****	
	Physic this stal di	1: To	1 ☐ Yes 2 No ☐ 27. Manner of Death	1 □ Inpatient 2 □ E	R/Outpatien 28b. Time of	C 3L DOA	4 IX Nursing me	ome 5 Reside	ence 6 Other			
lon	th. : After s funer	tior	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	es 2 □ No	Edd. Bosonbo III	ow injury occurre			
Division of	or Attanafer deat Diractor: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, stre	eet, factory, office		28f. Location (S	reet and Number	r or Rural	Route Numbe	ar,
	tal or A s after al Dira ed in b	Cert	- I Homodo	building, etc. (Specify,	,			City or Tow	n, State)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the time restigation, in my opi	, date and place, nion, death occur	and due to the c red at the time, d	ause(s) and man ate and place, ar	ner as stand	ted. the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	C. 1.		29c. License	number	2	9d. Date signed	(Month, D	ay, Year)	
j	/		> K. suyam	suvean		D533	367	5	Sept. 2	1, 2	2004	
	5		30. Name and address of person who cor	mpleted cause of death (Item	23а) (Туре, І	Print)	. <u> </u>	i		2	0878	
			Dr. R. Shyamsu	ndar, 10810	Darr	estown 1	kd., #2	02, Ga	ithersh	ourq	, MD	
	Sta Regístr		31. Date filed (Month, Day, Year) SEP 2 4 2004	32. ja istrar's Signati	5	Sparks	/					

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Ma	arylan	-	artment of F		d Mental Hy	-	2001	31000
			Decedent's Name (First, Middle, L.	ast)			outo or	200111	2. Date of De	Reg. No	,009	3. Time of Death
	Physici		WALTER	L. WILS	ON				Month SEPT 2	Da		
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	or Location of D			2004 County of Death	12:55A M
			Gilchrist Hos	nice of B	s 1+-	imora		imore			altimor	
	Funeral		Social Security Number 6.	Sex 7. Ag		last birthday)	If Under 1 Year	If Under 24 I		rth		place (State or Foreign intry)
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	D .		Usual Residence of Decedent 10a. State 10b. County		10- 0						7 7 7 7 7 7	-2007
	aryia sho	5	Toa. State Tob. County		TOC. CIT	y, Town or Lo	cation					10d. Inside City Limits
	№ М 28а-1	ecto	MD Howa 10e. Street and Number	rd		Colur						1X Yes 2 □ No
	ours after death with the Marylan rel', or Items 23a or 28a-1 show Examilier met be ricilliau at	Funeral Director					10f. Zip Code			10g. Ci	tizen of What Cou	intry?
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	ter d	'n	1 ☐ Never Married 2 🖫 Married	Armed Forces?		.s. 13. V	Yes, specify Cub	an, Mexican, Pi	(Specify Yes or No uerto Rican, etc.)	-	 Race - Amer Black, White 	ican Indian, , etc.
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2☐XNo	Specify:			Specify: Bla	.ck
	72 hours after death w "naturel", or Items 23a	Completed	15. Decedent's E			16a. Deced	ent's Usual Occup	ation		16b. K	(ind of Business/Ir	ndustry
Í	thin 7	ple	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	life. E	kind of work done OO NOT use retire	during most of d)	working			,
4	od wil	Con	7th		,	Labo	orer			C	onstruc	tion
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene, Is marked other than "naturel; or Items 23a or 28a-f show aumatic event, the Modical Examitrational be reciliated.	O	17. Father's Name (First, Middle, Las	t)				18. Mother's l	Name (First, Middle,			
2	Men Men arke	ို	Walter F. W	ilson						dge:		
2	2 sh and Is m		19a. Informant's Name/Relationship						Rural Route Number			
5	l and fealth m 27 her t		Eryl S. Wilson	n - Wile	201 0				k, Colu			
5	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic events.		20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation 3 [Removal from State	200. P	emetery, crem	sition (Name of pattern of other place	1	Date		ocation - City or T	
	trent dury		`4 □ Donation 5 □ Other (Special		HO	gkins		9/	25/2004	H:	ighland	, MD
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		7	222 Part Enter the distance or con	WINOU	an				ton St I		ville,	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.	i. Do not ente	er the mode or dylr	ig, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)			ANCER					2	
	Examiner			Due to (or as	a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):						
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Ŝ	exec an an rial-tr		resulting in death) Last	Due to (or as	a consequ	uence of):						
2	cate be executed physician and the burial-transit	dlcal		େ d								
		Jed	IF FFAMILE.									
5	eath certifi attending	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregna		Ectopic pregnancy	,			23d. Date of delive	ery
	e dea he at led fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)				Month	Day Year
	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use as	Physician/Me	9 Unknown									
2	res tha igned be de	by	Part II. Other significant conditions	contributing to death bi	ut not resu	alting in the un	derlying cause giv	en in Part I.				he cause of death?
5	w requir been si should I	ted							_ XXY	res 2	□ No 3 □ Prot	pably 4 □Unknown
2	elaw hasb je 2 sl	Completed							24a. Was autop	an sy	24b. Were auto	psy findings available mpletion of cause of
		Ç							perto	mied? 2█ No	death?	2 🔀 No
2	iysicien: Th	Be	25. Was case referred to medical examiner?	11					Death (Check only o	ne)		
5	Physi this c	2	1 ☐ Yes ŽÇ No	Hospital:		ER/Outpatient		4 🗆 Nursing				y) Hospice
	ding h. After funer	lon	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Year)	28b. Time of Injury	28c. Injury Work	k?	28d. Describe h	now injur	y occurred	
2	deat deat stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not to		Int. At ho			Yes 2 □ No	006 1		141	
2	or All after of Direct in by	ertification:	4 ☐ Homicide determined	28e. Place of Inju- building, etc	S. (Specify	me, rarm, stre	et, factory, office		City or Tow	otreet an vn, State	d Number or Rura)	I Route Number,
-	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	29a. Certifier 1 ▼ Certifying P	hysicien: To the best of	of my know	wledne death	occurred at the ti-	ne date and ri-	and due to the	201122 (-)	and man-	
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Exe	miner: On the basis of and manner sta	examinat	tion and/or inv	estigation, in my o	pinion, death oc	courred at the time,	date and	and manner as si place, and due to	tated. the cause(s)
	ro th within ro th	Me	29b. Signature and Mol pertifier				29c. License	e number		29d. Dat	te signed (Month,	Day, Year)
			I All her	•			res	DOOS	58608			
	V		30. Name and ddress of person who	completed cause of de	eath (Item	23a) (Type, F	Print)		~ 3		22,	2004
			Kauser Kahn 9					a, MD2	1045			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signal	ture A	Soark					

	ř		For State	State	of Mary	yland	•	ertment of H		nd Mer		00	101	010	00
_			Registrar 1. Decedent's Name (First, Middle	le. Last)				incate or i	Death	2.	Date of Dea	Reg. No.		3. Time of	Death
P	hysicia	an	Thomas Fred		att						Month	Day	Year		_ M
	/Medic xamin		4a. Facility Name (If not institution					4b. City, Town, or	Location of		ptemb		2004 ounty of Death	5:05	_Р
	Xamiii	iei	Wilson Health (-				Gaither					Montgor		
Fu	neral		5. Social Security Number	6. Sex		in yrs. las	st birthday)	If Under 1 Year	If Under 24	4 Hrs. 8	Date of Birth	h	9. Birth	place (State o	r Foreign
	ector		577-03-5660	1 X M 2□ F		93	Yrs.	Months Days	Hours	1 .	(Month, Day	, 1911	000	nry) ippine	
D C			Usual Residence of Decedent 10a. State 10b. County			0- 01-	T	4'							
aryla	Shov	2			"	uc. City,	Town or Lo							10d. Inside Ci	•
Me M	- ag	Director	MD Monts	gomery			Gai	thersburg	3			40.00			2 110
with	Dec	급						10f. Zip Code 20877	,				n of What Cou		
eath	18 23	Funeral	419 Russell A		ecedent Eve	er in U.S.	13 V			in? (Specify	Yes or No-		ted Sta		
fter d	iner	Fun	1 Never Married 2 Mar	Armed	Forces?	J. II. O.O.		Vas Decedent of Hi Yes, specify Cuba	in, Mexican,	Puerto Ric	an, etc.)	1.4.	Black, White,		
Irs at	o la	by	3 XWidowed 4 ☐ Divorced	If Yes, Year or	s 2 □ No Give Dates: V	IIWW	1	☐ Yes 2X No	Specify:			Sp	ecify: Whi	te	
2 S	ical 8	ted		nt's Education	الب		16a. Deced	lent's Usual Occupa	ation			16b. Kind	of Business/In		
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d wij	E #	Completed		4		11	Sec	al Manago urity Adı	min.				eral Go	vernme	nt
LING X 1 X 1 2 - 2000 Co. be filed within 72 hours after death with the Maryland half Hygiene.	d oth	Be	17. Father's Name (First, Middle,						18. Mother's	's Name (Fi	irst, Middle,	Maiden Su	rmame)		
Men	atic	2	Thomas B. Wy						Elsi		uckley				
12 sh	Taura Taura		19a. Informant's Name/Relations		1			g Address (Street a				-			
Tand Tealth	ther t		Beverly J. Gra	Italii / Dai			Ce of Disnos	9 Kirkwa sition (Name of	11 Ter	race,	Poto		MD 208 tion - City or To		
i of s	: # ite		1 ☐ Burial 2 【XCremation		m State	Metr	netery, crem	natory or other plac Ltan	e) S						
Dallillore, Mai yialla 21213-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	rtant		* 4 □ Donation 5 □ Other (\$ 21. Signature of Funeral Service				Crema	tory	1	Septem 28, 2	2004	Alex	andria	. Virg	inia
Deng Dem	any ir		MEACYA.S	tures			De	Name and Addres	Drive,	Devol Gait	L Fune Chersb	ral H urg,	ome, 10 MD 208) East 77	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications tha	t caused the	e death.			-					Approximate Interval Bety	
Phys	sician		Immediate Cause (Final disease or condition	8	rd-	SK	(10	Dema	1 kg	rile	100			Onset and D	
	dical		resulting in death)	a. Due t	to (or as a c	onseque	nce of):	,	0					(= 1 1 4	rung
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The law requires that the death certifi	been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o								23d	. Date of delive	arv	
leath D	atter d for t	clar	in the past 12 months?		e birth 2 [gnant at tim			Ectopic pregnancy Other (specify)					Month	,	/ear
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s tha	ned e det	by P	Part II. Other significant conditi	,	death but n	ot resulti	ing in the un	iderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to the	ne cause of de	eath?
w requires t	en sig	ed	Aschene	iecar	deo	m	Tox	allry			1 🗆 Y	es 2 🗆 K	lo 3 ☐ Prot	ably 4 🗆 U	Inknown
a v	2 sho	ompleted	Cornes	artie	1 de	L.	Lee	- 1			24a. Was a		4b. Were auto	psy findings a	available
로 ^원	ate ha	Com	mixte	iche.	uty	ail	use	. Chem	cano	nue	perfor		death?		1030 01
V II de la la la la la la la la la la la la la	artific ctor,	Be (25. Was case reterred to medical examiner?		0					beath (C	heck only or	18)			
Physicien:	his o	2	1 ☐ Yes 2 ☐ No		Inpatient				4 Minurs				Other (Specif	y)	
e de la	tor: After this certificate has the funeral director, page 2	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	ng (M	te of Injury o <i>nth, D</i> ay Ye	ea <i>r</i>) 28	8b. Time of Injury	28c. Injury Work	ς?		. Describe he	ow injury o	ccurred		
ttending death.	the f	icat	3 ☐ Suicide 6 ☐ Could	not be	on of Injuny	- At hom	o form etre	M 1 1	Yes 2∏No		Location (C	trant and M	lumber or Rura	I Davida Mumb	ha.
l or A	Dire d in b	ertification;	4 Homicide determ	nined bui	Iding, etc. (Specify)	e, iaiii, stie	et, ractory, office		201.	City or Town		unber of Aura	I HOULE IVUITE	Jer,
LIVISION To the Hospitel or Attending within 24 hours after death.	To the Funeral Direct completely filled in by	cal C	29a. Certifier 1 Certifyin	ng Physician: To t Examinar: On the	he best of m	ny knowle	edge, death	occurred at the tim	ne, date and p	place, and	due to the c	ause(s) and	d manner as s	ated.	
the H	the F	Medical	one) 29b. Signature and title of certifie	and ma	anner stated	j.		29c. License							
To	5 9	-	29b. Signature and title of certifie	+ 4.	. ,	,		29C. License	number	photo:	2		igned (Month,		200./
			11 tralle	efers	relet	Ch.	all	1 10	TIL	7		of te	maes	2 70	04
	8		30. Name and address of person				1	*		,		-			
	Sta	te.	H. Robert Birs 31. Date filed (Month, Day, Year,) 32	D., Z. Registrar's	O1 K Signatur	usseT	1 Avenue	, Gait	nersb	urg, 1	MD 208	8//		
F	Registr	_	OCT 0 8 2		cheva	_	6	Son K							
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			For State Registrar	State of M	larylan	•	artmen rtificate					jiene	001	
	Dhysisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dear		UUL	3. Time of Death
	Physici /Medio		Irving Yigdal	.1							Septemb	-	Year 2004	1:30 ^{p M}
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. Cc	unty of Deat	h
			Randolph Hills 1 5. Social Security Number 6. Se			f= =4 l= (-4b =44	Whe If Under	ator	If Under:	O.4 Uso			ontgom	
П	Funeral Director			3X 7. A	9e (in yrs. 78	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) July 10 ,	Year) 1926	9. Birt Co	hplace (State or Foreign untry) Jersey
			Usual Residence of Decedent								July 10,	1720	116 M	dersey
	nylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation		-					10d. Inside City Limits
	Ba-f s	Director	Maryland Montgor	nery	S	ilver	Sprin	ıg						1 ☐ Yes 2 🛣 No
	with th	Die	10e. Street and Number				10f. Zip				1	0g. Citizer	of What Co	untry?
	s 23	era	15400 Bassett La	ane 12. Was Decedent	Ever in II	6 12		20906		-:-2 (0	-4- V N-	USA	Dana Ami	
	ther de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	?		f Yes, spec	ify Cuba	spanic Origin, Mexican	gin? (Spe 1, Puerto l	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
99	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWI		1 ☐ Yes 2	2 ₹ No	Specify:			Sp	ecity: Wh	ite
Maryland 21215-0036	72 hours after death with the Maryland 'naturel', or Items 23e or 28e-f show dical Evar, divernment be modified at	Completed	15. Decedent's Edi (Specify only highest grad				dent's Usua kind of wor			t of worki	20	16b. Kind	of Business/	Industry
2	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired,	i ing most	i di woikii	,9			
2	lled w tygiei her ti		12 17. Father's Name (First, Middle, Last)			Cha	rter	Bus			15: 1 10:11			tation
anc	ntal Hed of	Be							18. Mothe	ers Name	(First, Middle, M	Maiden Su	mame)	
Ž	should ad Me mark matic	은	Phillip Yigdall 19a. Informant's Name/Relationship (T	vne Print)		19h Mailir	n Address	/Street a			<u>Ittles</u> IRoute Number		Ctoto 7	lia Cadal
\mathbf{z}	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23e or 28e-f show amportant: If Item 27 is marked other than "naturel; or Items 23e or 28e-f show amportant: If Item 27 is marked other traumatic svent, Ite Medical Exact is at marit be rediffied at once.		Evelyn J. Yigdall								ver Spr			
Baltimore,	f Hea f Hea Item othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	ne of		D	ate		ion - City or	
E	Page Int: I		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,		Met	emetery, crer ropol remator	itan "	ner place	" i	200	ember 4	Aleva	ndria	Virginia
a	permit. Depertin Imports any inju		21. Signature of Funeral Service Licens	See 0				d Addres	s of Facility		Funeral	Homo	Tna	virginia
<u> </u>	827 2 8		(inches)	Hole		50	00 Uni	vers	sity	Blvd	, W, Si	lver	Spring.	, MD 20901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	cations that cause e cause on each I	d the death ine.	n. Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Septice	mia									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		uence of):			-					Days
		-	Sequentially list conditions,	b. — Due to (or as	a conseni	ience of):								
	t t insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (21 41	4 0011004	01,00								
ć	exection and and items	Еха	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):							-	
8760,	icate be executed physicien and s the burial-transit	cal		d										
9	intifica ing ph a as th	Physiclan/Medical	IF FEMALE:										İ	
Вох	death certific e attending p id for use as	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pre					23d.	Date of delivery	
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of de	eath 5	Other (spe	ecify)					WOTH	Day Year
۵.	The law requires that the de ste has been signed by the a page 2 should be detached to	h h	Part II. Other significant conditions co	ntributing to death b	out not resu	ulting in the ur	iderlying ca	iuse give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
ds,	uires tha signed Ild be del	Completed by	Parkinson's Disea											bably 4 Dunknown
Vital Record	w requir been si should	lete									24a. Was ar	2	th Ware aut	opsy findings available
Re	The lay te has age 2	mo									autopsy	y ned?	prior to co death?	ompletion of cause of
		a)	25. Was case referred to medical						26. Place	of Death	1 Yes 2		1 □ Yes	2 No
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	- = E		27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28	Bc. Injury Work			8d. Describe ho			
sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				M	1 🗆 Y	es 2 🗆 N					
Division	in Parts	Certification;	4 Homicide determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, stre	eet, factory,	office		2	8f. Location (Str City or Town,		ımber or Rur	al Route Number,
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	e Hos 24 h Fun e Fun	edical	(Check only 2 Medical Exami	iner: On the basis of and manner st	f examinat	ion and/or inv	estigation,	in my opi	nion, deatl	h occurre	d at the time, da	ite and pla	manner as: ce, and due i	stated. to the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date sig	gned (Month,	Day, Year)
c	11		Muta C	They &				D08	944			Sept	ember	24, 2004
4	(1)		30. Name and address of person who ca	ompleted cluse of o	leath (Item	23а) (Туре, І	Print)							
			Martin C. Sharge				ut Av	enue	, Ken	sing	ton, MD	2089	5	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 4 20	32. Registr	ar's Signat	ure \mathcal{G}	So	acks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City. 4a. Facility Name (If not institution, give street and number Town, or Location of Death Examiner 7. Age (In yrts. last birthday) II Under 24 Hrs. 6. Sex Birthplece (State or Foreign Country) Social Security Number If Under 1 Year **Funeral** Days Hours 1 M 2 □ F Director March Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Madical Examiner hast be notified at 1 Yes 2 □ No Be Completed by Funeral Director Marylana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) aintenance Te 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be innent of Health and Mental shift them 27 is marked o ong 19a, Inform t's Name/Relationship (Type, Print) lug er 19b. Mailing Address (Street and Number of ral Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Department of important: If eny injury or once. * 4 Donation 5 Other (Specify) Lanes U.M.Churc h Cem 21. Signature of Funeral Service Pensee 22. Name and Address of Facility 23a. Pert1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EmphyseMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 11No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 1 Yes 2 No Dther: Certification: To 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the museum.
within 24 hours after death.
To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

DHMH 17 Rev 1/2001

State

the

30 i

29b. Signature and title of certifier

ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Poistar's Signature

29c. License number

05

2113

21702

29d. Date signed (Month, Day, Year)

October

04-06538 David Am RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rid) 	Ames		1 - For State Registrar	State of I	Maryland / D	epartment of Certificate			lental Hy	giene Reg. No	0001	31003
ı	Physica /Medi		Decedent's Name (First, Mid Davi	die, Last) d C. Ames					2. Date of De	er 0	7, 20 04	3. Time of Déath 0739A . M
	Examir		4a. Facility Name (If not institute University Ho		ər)	, ,	wn, or Location	n of Death		40	. County of Death	
	Funeral Director		5. Social Security Number 218–94–5449	6. Sex 7 1 🛣 M 2 🗆 F	Age (In yrs. last birth 39 Yı	Months [Year If Under Days Hours		8. Date of Bir (Month, Da 03–18–19	rth a <i>y, Year)</i> 165	9. Birthr Cour Mary1	
	faryland show	_	Usual Residence of Decedent 10a. State 10b. Coun	•	10c. City, Town						1	0d. tnside City Limits
	the Ma 28a-fs	ecto	MD NA		Bal	timore 10f. Zip Co	ndo.			10- 0	tizen of What Cour	1 Y Yes 2 □ No
	ath with 23a or	al Dir	639 N. Woodington	Avenue		101. Zip Ot	21229			Tog. Cil	USA	itry ?
920	after des	by Funeral Director	11. Marital Status 1 Never Married 2 X Ma 3 Widowed 4 Divorce	12. Was Decede Armed Force 1 ☐ Yes 2]	s? Q No	13. Was Deceden If Yes, specify	t of Hispanic C Cuban, Mexic	an, Puerto I	cify Yes or No Rican, etc.)	>-	14. Race - Americ Black, White,	
21215-0036	should be filed within 72 hours nd Mental Hygiene. markad other than "natural", matic avant. It's Mydical Exa	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	ent's Education est grade completed) College (1-4c		ecedent's Usual C Give kind of work of fe. DO NOT use i	done during mo etired)	ost of workin	ng	16b. K	ind of Business/Ind	•
	be fflectal Hyg	Be	17. Father's Name (First, Middle	e, Last)				her's Name	(First, Middle	, Maiden		116
Maryland	should be nd Mental markad o	ို	Albert Ames 19a. Informant's Name/Relation	ashin (Type Print)	10h A	faiting Address (O			el Ames			
	1 and 2 sho Health and am 27 is m thar traum		Charlene Mercer-A			89 N. Woodi					or Town, State, Zip 29	Code)
Baltimore,	e = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (20b. Place of D cemetery,	isposition (Name crematory or othe orial Park	of r place)		ate	20c. Lo	ocation - City or To	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funerat Service	e Licensee	-	22. Name and A Wylie Fune		1	Gilmor		Balto,MD 21	
	Livate be executed / Medical Examiner site burial-transit site burial-transit	Examiner	22. Part . Enter the disease, shock, or heart failure. List . Lis	a Due to (or a b Due to (or a c.	line.	nsikit h	11	s cardiac of	r respiratory a	rrest,		Approximate Interval Batween Onset and Death
P.O. Box 68760,	The law requires that the death certificate by the has been signed by the attending physic bage 2 should be detached for use as the b	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□ Unknown	2 Fetal death at time of death	3 □Ectopic pregn 5 □ Other (specil	y)					Ďay Year
rds,	w requires to been signe should be d	by	Part II. Other significant condit	tons contributing to death	but not resulting in tr	e underlying caus	e given in Part	l.	239. Did to		se contribute to th No 3 □ Proba	e cause of death? ably 4 Unknown
Vital Records,		Completed									prior to con death?	nsy findings available apletion of cause of
of Vit	lysicii iis cer direci	To Be	25. Was case referred to medic examiner? 1 □ Yes 2 □ No	Hospital: 1 XInpa	tient 2 ER/Outpa	itient 3 DOA	Other		(Check only o		S □Other (Specify)
	ding h. After fune		27. Manner of Death 1 Natural 5 Pend	ing 28a. Date of In (Month D	jury 28b. Tim Day Year) Inju	e of 28c.	Injury at Work? 1 ☐ Yes 2 🛣	,	8d. Describe h			
Division	al or Attanding s after death. Il Diractor: After ed in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	I not be 28e. Place of I	njury - At home, farm etc. (Specify)	street, factory, of		-	Rf Location /S	treet and	AS SHOT Number or Rural 41 WX(T)	Route Number, tan Rund
	To tha Hospital or within 24 hours after to tha Funaral Discompletely filled in	edical (29a. Certifier 1 Certify (Check only one)	ing Physician: To the bes I Examiner: On the basis and manner:	or examination and/o	eath occurred at the r investigation, in a	ne time, date a my opinion, de	nd place, ar ath occurred	nd due to the o	ause(s) date and	and manner as sta place, and due to	ited. the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifi	011	2/		cense number				a signed (Month, D	-
1130	M'		30. Name and address of person	who completed cause of	death (Item 23a) (Tv		C.M.E.				per 10, 2	.004
	U I		JACK M.	Tirus m.D.			Penn S	treet	, Balt:	imor	e, Maryla	and 21201
:	Sta Registr		OCT 1 2 2004	32. Regis	trar's Signature	contil						

DHIVIN 17 P.8V 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death James F. Ash, Sr. 0300 AM october 2001 U 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heatthca -Agrils Baltimo n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year, 1910 March 3, 1910 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) 1 XM 2□F 212-07-0295 Yrs Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore 1 Yes 2 No 10f. Zip Code 21227 10e. Street and Number 10g. Citizen of What Country? 813 Rambo Court United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver Food Warehouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Richard H. Ash Bertha Cline 19a Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Frances Stielper / Daughter 503 Nautical Lane, Ocean City, Maryland 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 10/13/2004 Elkridge, Maryland * 4 ☐ Dogation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign ture of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) TYPS 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY ORONARC 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DISEASE DIBSTRUCTIVE PULMONARU HRONK 25. Was case referred to medical examiner?

Physician /Medical Examiner

once

Physician

/Medical

10a. State

Director

β

Completed

Examiner

Funeral

Director

28a-f show

or Items 23a or

other treumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours atter Department of Healith and Mental Hygiene.

The proporterist if item 27 is marked other than "naturel; or lite any injury or other treumatic event, the Mealical Esemina

Saltimore, Maryland 21215-0036

with the Maryland

Examiner use as the burial-transit and Physiclan/Medical

been signed by the attending physician should be detached for use as the burial has

Division of Vital Records, P.O. Box 68760, S & S tet or Attending Physicien: The safter death.

s after death.

al Director: After this certificate of in by the funeral director, page of in by the funeral director, page of in by the funeral director, page of in by the funeral director.

24 hours a within 2 To the 1

Completed

Be

2

Certification:

Medical

1 ☐ Yes 2 X No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Thomicide

29b. Signature and title of certifier

AN State Registrar

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

M.D. MPH

29c. License number P16766

26. Place of Death (Check only one)

MD,

Other 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) UCrober 10, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 XInpatient

28a. Dite of Injury (Month, Day Year)

YED MASOOD BALTIMORE

Hospital:

31. Date filed (Month, Day, Year) WIT 1 2 2004 32. Registrar's Signature

3 DOA

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

cian	1 - For State Regis			•	ertificate of	Health and M Death	Reg	.n2004	3 9 9 5
	1. Decede	nt's Name (First, Middle, La	charles	Russell	Aldrich		2. Date of Death Month	Day Year 5 200	// 1
ical ner	4a. Facility	Name (If not institution, give	e street and number,		4b. City, Town,	or Location of Death	10	4c. County of Dea	
ie.	Fran	KlinSquare	Hospita	1	Ruseda	le		Baltini	ere
	216	-24-0614	DXM 2□F	ge (In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Aug. 8,19	(ear) 9. Bi	rthplace (State or Foreig country) ew York
	Usuel Res	idence of Decedent 10b. County		10c. City, Town o	or Location				10d. Inside City Limit
tor	Mary	land Ba	altimore			Edgemere			1 □ Yes 2/2/N
Director		t and Number 3 Wood Avenue	<u>a</u>		10f. Zip Code	77.		g. Citizen of What C IJnited	
erai	11. Marita		12. Was Deceden	Ever in U.S.	13. Was Decedent of	Edgeme Hispanic Origin? (Spe		14. Race - Am	iencan Indian,
by Funeral	1 □ Ne	ever Married 2 Married idowed 4 Divorced	Armed Forces 1 Yes 2 Hes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rićan, etc.)	Black, Wh Specify: Wh	ite, etc.
		15. Decedent's E (Specify only highest gra	ducation ade completed)	1 (0	ecedent's Usual Occu	during most of worki	ng 16	6b. Kind of Busines	s/Industry
Completed	_	tary/Secondary (0-12)	College (1-4or	5+) li	ife. DO NOT use retire Truck Dri			Truckin	a Co.
e Co		ears 's Name (First, Middle, Last			TLUCK DI.	18. Mother's Name	(First, Middle, Ma		5
o Be		on Aldrich				Iva Bas	ford		
-		mant's Name/Relationship (Mailing Address (Stree		ni Route Number, C nere, Mar		Zip Code) 219
	20a. Meth	od of Disposition		20b. Place of D	isposition (Name of crematory or other pla		Date 20	c. Location - City o	r Town, State
	1 ⊠ 5	Burial 2 Cremation 3 Contain 5 Other (Special	Removal from State fy)		Hill Mem.	1	/2004	Middle Ri	iver, MD
	21. Signa	ture of Funeral Service Life	nsed	Inl	22 Name and Addr			undalk l	nc
		1/100/1	" Kris	110/	7922 Wise	Ave. Du	ndalk, Ma	aryland 2	1222
		. Enter the disease, or com ck, or heart failure. List only	plications that cause one cause on each	ed the death. Do not	t enter the mode of dy	ing, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	disease of resulting	e Cause (Final or condition in death)	a seve	re n.	SCVD				
			Due to (or a	s a consequence of)):				
er	Sequenti if any, lea	ally list conditions, ading to immediate inter Underlying	b. Due to (or a	s a consequence of)):				
Exan iner	Cause (Ca	ted events	c.						
		in death) Last	Due to (or a	s a consequence of)	:				
dical			d						
/Me	IF FEMA		23c. If yes, outcom	e of pregnancy				23d. Date of d	eliverv
cian	23b. Was in th 1 = 9 =	s decedent pregnant ne past 12 months? Yes 2 \sum No Unknown	1 Live birth	2 Fetal death at time of death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		Month	Day Year
ys	Part II. Of	her significant conditions	contributing to death	but not resulting in t	he underlying cause g	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
y Physician/Medi							1 ☐ Yes	2 □ No 3 □ I	Probably 4 Unknow
by							24a. Was an autopsy	prior to	autopsy findings availab completion of cause of
þ							, performe	ed? death?	
à	-							□ No 1 1 1 Ye	
e Completed by	25 Was	case referred to medical							_
To Be Completed by	25. Was exam	iner? 'es 2 No	Hospital: 1 Inpa		allerit 30 DOA	ther: 4 - Nursing Ho	Check only one) ice 6 ☐ Other (Sp	s 2 No
To Be Completed by	25. Was exam	iner? /es 2 No er of Death latural 5 Pending	28a. Date of In (Month, E	jury 28b. Tin	me of 28c. Injury	ther: 4 - Nursing Ho	(Check only one) ice 6 ☐ Other (Sp	s 2□ No
To Be Completed by	25. Was exam	iner? /es 2 \(\sum \) No er of Death	28a. Date of In (Month, D	jury 28b. Tir lay Year) Inju	me of 28c. Injury	ther: 4 Nursing Houry at ork? Yes 2 No	The Check only one one of the Check only one of the Check only one of the Check only one of the Check on the	oce 6 Other (Sp. vinjury occurred	s 2□ No
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To Be Completed by	25. Was exam 12 27. Magr 2 3 3 3 4 5 29a. Cer (Ch on)	iner? Yes 2 No No No No No No No No No No	28a. Date of In (Month, Don be dd 28e. Place of I building,	jury Year) 28b. Tin Injury - At home, farm etc. (Specify) st of my knowledge, of examination and	n, street, factory, office death occurred at the for investigation, in my	ther: 4 Nursing Houry at ork? Yes 2 No	me 5 ☐ Residen 28d. Describe how 28f. Location (Stree City or Town, and due to the cau ed at the time, dat	ice 6 Other (Sp. vinjury occurred set and Number or instale)	es 2 No Necify) Paral Route Number, as stated. ue to the cause(s)
Certification: To Be Completed by	25. Was exam 12 27. Magr 2 3 3 3 4 5 29a. Cer (Ch on)	iner? Yes 2 No No No No No No No No No No	28a. Date of In (Month, E) 28b. Place of I building, 28c. Place of I building, 28c. Place of I building, 28c. Place of I building,	jury Year) 28b. Tin Injury - At home, farm etc. (Specify) st of my knowledge, of examination and	n, street, factory, office death occurred at the for investigation, in my	ther: 4 Nursing Houry at ork? Yes 2 No	me 5 ☐ Residen 28d. Describe how 28f. Location (Stree City or Town, and due to the cau ed at the time, dat	oce 6 Other (Sp. vinjury occurred set and Number or I State)	es 2 No Necify) Paral Route Number, as stated. ue to the cause(s)
Certification: To Be Completed by	25. Was exam 152 27. Manr 1 2 3 3 3 3 4 5 29a. Car (Ch on 29b. Sign	riner? Yes 2 No No No No No No No No No No	28a. Date of In (Month, E) 28b. Place of I building, 28c. Place of I building, 28c. Place of I building, 28c. Place of I building,	jury lay Year) 28b. Tin lnju njury - At home, fam etc. (Specify) st of my knowledge, of examination and/ stated.	n. street, factory, office death occurred at the for investigation, in my	ther: 4 Nursing Houry at ork? Yes 2 No	me 5 ☐ Residen 28d. Describe how 28f. Location (Stree City or Town, and due to the cau ed at the time, dat	oce 6 Other (Sp. vinjury occurred set and Number or I State)	ecify) Rural Route Number, as stated. ue to the cause(s)

DHMH 17 Rev 1/2001

Aldrich, Charles Baltimore, Maryland 21215-0036

	1 - For State Registrar			Certific	ate of	Death		Reg.	No.	31996
	1. Decedent's Name (First, Middle						2. Dat	e of Death	Day Year	3. Time of Death
ian cal	Harold Evere	tt Anders	on					ober		10:09 A M
ner	4a. Facility Name (If not institution			4b. 0	_	or Location of	Death		4c. County of Dea	
	Greater Baltin 5. Social Security Number		L Center Age (In yrs. last bir	thday) If U	TOW nder 1 Year	SON	4 Hrs. 8 Date	e of Birth	Balti	nore httplace (State or Foreign
	349-10-5580	18 M 2□F		Yrs. Mon		Hours		nth, Oay, Ye	ar) C	inois inois
	Usual Residence of Decedent						, ing.			
_	10a. State 10b. County		10c. City, Tow							10d. Inside City Limits 1 Yes 2 No
Funeral Director	MD Baltir	nore	Baldwin		7: 0 :					
5	10e. Street and Number 13601 Devonfie	ld Drive			Zip Code 21013			US.	Citizen of What C	ountry?
erai	11. Marital Status	12. Was Decede	nt Ever in U.S.			Hispanic Origi	n? (Specify Ye		A 14. Race - Am	erican Indian.
Fun	1 Never Married 2 Married	Armed Force ried 1 XYes 2	s?	If Yes,	specify Cub	an, Mexican,	Puerto Rican, e	etc.)	Black, Whi	
ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	3:	1 L Ye	s 2KDNo	Specify:			Specify: W	hite
Completed		t's Education st grade completed)	16a.	Decedent's (Give kind o	f work done	during most of	of working	16b	. Kind of Business	s/Industry
щdш	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. DO NO	T use retire	d)				
	17. Father's Name (First, Middle,	[251)	ACC	ountar	I L	18 Mother's	s Name (First,		counting	
Be c	47	nderson				Hanna		anson	on gamana)	
2	19a. Informant's Name/Relations	hip (Type, Print)	19b	. Mailing Add	ress (Street				ry or Town, State,	Zin Code)
	Mildred W. Ande		1	-					MD 210	
	20a. Method of Disposition	•	20b. Place of	Disposition y, crematory	(Name of		Date	20c	Location - City of	Town, State
	1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation /3 ☐ Other (S		10				0/11/04	Swe	eet Air.	MD
	21. Signature of Funeral Service	Liconsea				ess of Facility	.,, .		1050 York	
	1 eta	J. Cliny		Ruck	Towso	n Fune	ral Hom		Towson, I	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications at caus only one caus on each	ed the death. Do i	not enter the	mode of dyi	ng, such as ca	ardiac or respir	atory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	V	SEPTI	CEM	IA					Onset and Death DAY 5
	resulting in death)	Due to (or	as a consequence	of):						
<u></u>	Sequentially list conditions,	b. Due to (or	as a consequence	of):						
xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	\$ 200 10 (0)	a consequence	,-						/
	that initiated events resulting in death) Last	CDue to (or a	as a consequence	of):						
caiE		C d.								
ear		-								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnancy 2 ☐ Fetal death	3 Ector	ic pregnanc	v			23d. Date of de	
sick	in the past 12 months?		at time of death		r (specify) _				Month	Day Year
	9 Unknown			the undertifie	00.000	on in Ba≠1	22.	Did tobacc	n usa contribute t	o the cause of death?
Ö	Part II. Dther significant condition DISSEM IN ATEI		SCULAR				236	1 ☐ Yes		robably 4 Unknown
ompieted	VIJENINA IEI	INTERNA	JULAK	WAGUI	-n 1 10	14	-			
id L					-		248	 Was an autopsy performed 	prior to	utopsy findings available completion of cause of
C								Yes 2X		2 X No
o De	25. Was case referred to medica examiner?	Hospital:	tion ADEDIO	*******	T DOA Oth	205	of Death (Check		о Пон <i>(</i> т	
-	1 Yes 2 No 27. Manner of Death	28a. Date of I	jury 28b. 1	Time of	28c. Inju	4 L Nurs			6 ☐ Other (Spenjury occurred	ecity)
tion	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	Day Year)	njury M		rk?]Yes 2.∐No				
ertification;	3 Suicide 6 Could 4 Homicide determ	sined 286. Place of	Injury - At home, fa etc. (Specify)	rm, street, fa	ctory, office		28f. Loc	ation (Street or Town, St	and Number or R	ural Route Number,
Cert	4 Lionnoide	building,	oto. (opecity)				Only	or rowin, ot	u10/	
edical (29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the be Examiner: On the basis	st of my knowledge	death occur	rred at the ti	me, date and	place, and due	to the cause	(s) and manner a	s stated.
Ö	one)	and manner	stated.							
Z	29b. Signature and title of certifie	•			29c. Licens			1 001	Date signed (Mon.	th Day Vacal

Division of Vital Records, P.O. Box 68760,

Anderson, Hardel Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENJAMIN SCOTT HERMAN, MD 31. Date filed (Month Day Year) 2 2004

MD

GOTI NORTH CHARLES STREET 32. Registrar's Signature

TOWSON

00060632

October 8

MD

21204

2004

DHMH 17 Rev 1/2001

		•	For State Registrar	State of	Maryland		artment <i>rtificate</i>			nd Mer		giene Reg. NQ. ()	The state of the s	31997
	Physici		1. Decedent's Name (First, Middle		DOK					2.	Date of Dea	ath Day 4	Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution,	, give street and numb	oer)		4b. City, To	own, or l	Location of	Death		4c. Cou	nty of Dea	th
			Northwest Hospi	tal					1stow				timoı	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 💢 F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2	Min.	Date of Birt (Month, Day	y, Year)	9. Birt	thplace (State or Foreign puntry)
	Director		284-10-9160 Usual Residence of Decedent		88	115.				Jτ	ine 20	, 1916	0 0h:	io
	land		10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
	Many f sh	ξ	MD			Balti	more							1√ Yes 2 No
	r 28e	rec	10e. Street and Number				10f. Zip C	Code				10g. Citizen	of What Co	ountry?
	h with	ai D	3800 Old Court	Road				2120	8				_USA	
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Examiner must be nutified at	by Funeral Director	11. Marital Status	12. Was Deced		13.	Was Decede f Yes, specif	nt of His y Cuban	panic Origi , Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	- 14. F		encan Indian, e, etc.
98	or It	F	1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes 2 If Yes, Give	∑ No		1 □ Yes 2]						-16	hite
21215-0036	urel'.		3 N Widowed 4 □ Divorced	Year or Date		16a Dans	dent's Usual	000000	tion			16b. Kind of		
5-	"net	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	kind of work DO NOT use	done du	irina most o	of working		100. Killa o	Dusiness	maustry
12	within ene. than "	шс	Elementary/Secondary (0-12)	College (1-4	lor 5+) 5+		teache	er				ed	ucati	on
	filed Hygie other ent, I	Be C	17. Father's Name (First, Middle, I	Last)					18. Mother	's Name (F	irst, Middle,	Maiden Sum		
an	should be nd Mental marked o	ToB	Philip S. Sich	erman						Hermi	ne Fe	der		
Maryland	S DE	,-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street an	nd Number	or Rural R	oute Numbe	er, City or To	wn, State, 2	Zip Code)
	1 and 2 Health a em 27 Is		John Book/son				hellis		irt Ov	vings	Mills	MD	2111	7
J.	of He of Her		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from St	Cerri	ce of Dispo etery, crem	sition (Name natory or oth	of er place)	Date		20c. Locatio	on - City or	Town, State
Ē	Pages nent of ent: If It ury or o		'4 XDonation 5 □Other (Sp	pecify)					i					
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If Item eny injury or othe once.		21. Signature of Funeral Service I	Wade, Di	Legitox	St	Name and ate And 1timo:	nato	my Bo	ard 6 1201	55 W.	Balti	more	Street
	*		23a. Rart1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death.	Do not ent	er the mode	of dying	, such as c	ardiac or re	spiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	4	MUDI	care	eles	07	who	usel	3			Onset and Death
	/Medical		resulting in death)	Due to (or	r as a conseque	nce of):			. ()-	1	7			
	Examiner		Sequentially list conditions.	b	4 ry 80	ou	2	W o	lla	2 6	res	7		
	ם ד	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a cooseque	nce of):								
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to (or	r as a conseque	nce of)>								
8760,	ate be executed obysician and the burial-transit	三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田		20010 (0)	ATIO	1)10	Le	10	Me a	200	on (0)			
	physi physi s the l	dical		d	100	YLE			Bran		5			
9 x	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnanc	y						23d.	Date of de	livery
Вох	that the death cer ed by the attendin detached for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnai	th 2 Fetal dent at time of deal		Ectopic pred Other (spe						Month	Day Year
Ö.	the c yy the achec	hysi	9 Unknown	9□ Unknow	vn									
٦	w requires that s been signed b should be deta		Part II. Other significant condition	ns contributing to dea	th but not resulti	ing in the u	nderlying car	use giver	n in Part I.		23e. Did to	obacco use c	ontribute to	the cause of death?
Records,	quire an sig uld b	ed b									1 🗆 Y	res 212 No	3 □ Pr	robably 4 Unknown
000	aw re	plet									24a. Was autop		b. Were au	utopsy findings available completion of cause of
Ä	The law ate has page 2	Completed by									perfo	rmed?	death?	2□ No
Vital		Be	25. Was case referred to medical examiner?		/				26. Place	of Death (C	heck only o	ne)		
f V	Physiclan: r this certific ral director,	Tof	1 Yes 2 No			NOutpatier			4 🗀 Nut:	sing Home	5 🗆 Resid	dence 6 □0	Other (Spe	cify)
n of	ding Pl		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of (Month)	Injury 28 Day Year) 28	8b. Time of Injury		c. Injury Work			. Describe h	now injury occ	curred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investig				М		es 2□N		Landing /	Cannada and Adv		The stable of th
Division	or Ati	Certification:	4 Homicide determ	ined 28e. Place o	f Injury - At hom- g, etc. <i>(Specify)</i>	e, farm, str	eet, factory,	office		281.	City or Tou	vn, State)	imber or Hi	ural Route Number,
	Hospitel	Ce	29a. Certifier 1 Dertifyin	g Physician: To the b	ast of my knowle	edne deatl	h occurred a	t the time	n date and	place and	due to the	nause(s) and	manner as	stated
	Hos 24 ho Fun etely	edicai		Examiner: On the bas	is of examination									
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier				29c.	License	number			29d. Date sig	ned (Mont	h, Day, Year)
	- s - ō		> Pm	KILLIZ.	ww			7)	441	70		Oil	ode	4. 2001A
			30. Name and address of person	who completed cause	of death (Item 2	3a) (Type,	Print)							
			1A.J	IMPE	RIAL	,50	- M	\bigcirc	•	No	04			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatu	9 /	park	1						
	Regist	rar	OCT 1 2 200	4	1"	1								

, J <u>T</u>	.2		For State Registrar	State of Maryl	•	artment of Heartificate of De			iene eg. No? 11 11 14	21600		
		Decedent's Name (First, Middle, Last)						2. Date of Dear	th	3. Time of Death		
	Physicia		Sheronda S. Butcher					Month OCTOBER	Day Yea 9, 2004	5:00a M		
10.	/Medic		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Loc		0010321	4c. County of De			
	⊏xamın	44. Pacinty Name (ir not institution, give street and number) UNIVERSITY HOSPITAL					BALTIMORE CITY					
			5. Social Security Number 6. S		rrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9.6	Birthplace (State or Foreign		
	Funeral Director		212-80-2097	□M 201F	30 Yrs.	Months Days H	lours Min.	8. Date of Birth (Month, Day 06-06-19	74 Ma	Country) ryland		
			Usual Residence of Decedent							-J		
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Exam and the righted at ance.		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
		ţ	MD NA		Balt	imore				1 Yes 2 □ No		
		Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?		
			309 N. Calhoun St. 3rd Fl.			21223			USA			
		Funerai	11, Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hispa	inic Origin? (Spe	cify Yes or No-	14. Race - Ar	nerican Indian,		
	ter d	ᆵ	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		f Yes, specify Cuban, M		Rican, etc.)	Black, W	hite, etc.		
99	Ir, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	:	1⊡ Yes 2XC No S	Specify:		Specify:	Black		
Ş	hou	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation	n		16b. Kind of Busines	ss/Industry		
5	in 72	Completed	lite DO N			kind of work done durin DO NOT use retired)	nd of work done during most of working					
2	with than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Cash	nier			Fast Food			
ი ი	Hygi Hygi ther	Ö	17. Father's Name (First, Middle, Last)		18.	. Mother's Name	(First, Middle,	Maiden Sumame)			
Maryland 21215-0036	d be	o Be	Rodney Brooks				Sarah M	. McDowel	.1			
≥	d Me mark mati	은	19a. Informant's Name/Relationship	Type, Print)	19b. Mailie	ng Address (Street and	Number or Rura	i Route Number	. City or Town, State	. Zip Code)		
₹	d 2 s th ar trau		Sarah M. Brooks/ Mothe	** *		N. Calhoun St						
	1 an Heal em 2 ther		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of			20c. Location - City	or Town, State		
ŏ	in the		1 XBurial 2 ☐ Cremation 3			matory or other place)	10-15-	Ωı	Lansdowne,	MD		
altimore,	t. Pa tant tant njury		*4 □ Donation 5 □ Other (Special Street Lice	,,	t. Zion Ce		1	04	Lansdowne,	TID		
Bal	Deparement of the property of		21. Signature of Filheral Source Lice	1/1/-//-		2. Name and Address of	Í			04047		
_	GD = 4 G		232 Part1. Enter the disease, or con	MAIN		Wylie Funeral				, MD 2121/		
п			shock, or heart failure. List only	one cause on each line.	eath. Do not en	er the mode of dying, st	uch as cardiac o	respiratory arr	est,	Interval Between Onset and Death		
m Ş	Physician /Medical Examiner		Immediate Cause (Final disease or condition . GINCHOT WOUND OF CHEST AND ABOUMEN									
			resulting in death)	Due to (or as a con	sequence of):							
	Examine		Sequentially list conditions	b								
	cate be executed physician and the burial-transit	Examiner	fi any, leading to immediate cause. Enter Underlying Cause. (Disease or injury									
		am	that initiated events resulting in death) Last									
Ö,		<u> </u>	1650king in dodiny cast	Due to (or as a con	sequence or);							
8760,		dicai	d									
9	ntific ng p	Mec	IF FEMALE:			· · · · · · · · · · · · · · · · · · ·						
Вох	death certifi e attending ed for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of delivery Month Day Year			
O.	that the death certificed by the attending properties as	by Physician/Me	1 ☐ Yes 2 ☐ No	4☐Pregnant at time 9☐ Unknown	of death 5	Other (specify)			Widnes	Month Day 19ai		
P.	at the by th	بار ک	9 ⊠Unknown					00 0111				
	es tha igned be det	b							cco use contribute to the cause of death?			
ord	v requir been si should	ed						1 🗆 Y	es 2 XNo 3□	Probably 4 Unknown		
Vital Records,	8 8 8	Completed						24a. Was a autops	n 24b. Were	autopsy findings available o completion of cause of		
æ	0 5 0	E						perform 18 Yes	ned? death	?		
ta	ı cian: Th certificate rector, pag	0	25. Was case referred to medical			26	3. Place of Death		1			
	8 0 D	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient	₹NOutpatie	nt 3 DOA Other:	4 🗌 Nursing Hon	ne 5 🗆 Reside	ence 6 Other (S	pecify)		
0	g Ph er th		27. Manner of Death	f 28c. Injury at Work?			ow injury occurred	njury occurred				
ion	Attending r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending investigation	A M 1 Yes 2 No S		SUBJE	SUBJECT WAS SHOT					
Division of	or Attendated after death	ertification:	3 ☐ Suicide 6 ☐ Could not to determined	eet, factory, office 28			M. Location (Street and Number or Rural Route Number, City or Town, State)					
Ö	alor afte I Dir d in		3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					838 N. FULTON ST, AP A DALTHARE, MO				
	Hospital 24 hours a Funerel 6 etely filled	alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							as stated.		
	To the Hospital or Attending Phythin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 X Medical Exa	miner: On the basis of exar and manner stated.	nination and/or in	vestigation, in my opinio	on, death occurre	o at the time, d	are and place, and d	ue to the cause(s)		
	To the within 2 To the complet	M	29b. Signature and title of certifier	e		29c. License nu	umber		9d. Date signed (Mo			
7	1)		> auch2_			OCME		OC	CTOBER 9,2	2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	710		ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201									
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 ,						
	Regist	rar	OCT 1 2 2004	Bank	A P	south						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3:50A M **Physician** OCTOBER /Medical give street and number) Facility Name (If not institution. 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number **Funeral** CAROUNA Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d, Inside City Limits 10b County item 27 le marked other then "naturel", or Items 23e or 28e-1 show other treumstic event, the Medical Examiner must be notified at MITIMORE 1 Yes 2 No MDCompleted by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death v Was Decedent Ever in U.S. Armed Forces 1 __Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE EXAMINER 18. Mother's Name (First, Middle, Maiden, Sumame) 17. Father's Name (First, Middle, Last Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Νī 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 Removal from State 10-11-04 ¹ 4 □ Donation 5 □ Other (Specify) C GREENE FUNERIN HOME 21. Signature of Funeral Service Licenses BATIMORE, MARYLAND 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** Dancrectic disease or condition resulting in death) 4-855 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **X**No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 🕊 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number 10-5.04 nus ne and address of person who completed cause of death (Item 23a) (Type, Print) \mathbb{O}_{ℓ} 6601 N. Charles Street Towson, Md. 21204 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 1 1 2 1 1 1							
	Physicia /Medic Examin	an	1. Decedent's Name (First, Middle, Last) GEORGIE BROWN	2. Date of Month	Death 3. Time	of Death		
X.			4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER	4b. City, Town, or Location of Death RANDALLS TO WO	4c. County of Death			
	Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. 8 Date of	Day, Year) Country)	9. Birthplace (State or Foreign Country) MD		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at 90ce.	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			City Limits		
		Director	MD CARROLL SYKE 100. Street and Number 912 GIBBONS AVENUE	101. Zip Code	10g. Citizen of What Country?	es 2. 2/3/ No		
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.			
-0036		by	3 DeWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: BLACK			
21215-0036		To Be Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired) CTICIAN SUPERVISOR	11 (OA)10 A1(20		
Maryland			17. Father's Name (First, Middle, Last) BOYD SHOFFEY	18. Mother's Name (First, Mid BARBARA	: 0			
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailii 19c. ASSAVAY/DAUGHTCR 912	ng Address (Street and Number or Rural Route Nu GIBBANS AVENUE SY	imber, City or Town, State, Zip Code)	784		
Baltimore,			20a. Method of Disposition 1 SuBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	matory or other place)	20c. Location - City or Town, State BALTIMORE, L	10		
Baltir	permit. F Departme Importar any injur		/ IFU	2, Name and Address of Facility AUGHN C. GREENE FUNE AUGHN BALTIMORE NATIL	PAL SERVICES	1229		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed by Secured within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and polycompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		23a. Pat 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respirator	ry arrest, Approxim	nate Between		
		edical Certification; To Be Completed by Physician/Medical Examiner	immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	. CHROTO ON 30 OFFICE NO.	12 5 42 5 ,			
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
8760,			that initiated events c. Due to (or as a consequence of):					
.O. Box 687				□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	Year		
s, P			Part II. Other significant conditions contributing to death but not resulting in the u	id tobacco use contribute to the cause o	of death?			
Division of Vital Record				24a. W au pr 1 □ Ye	utopsy prior to completion of death?	s available i cause of		
f Vita			25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check on an an an an an an an an an an an an an	esidence 6 ⊡Other (Specify)			
o uois			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No 28d. Descrii	be how injury occurred			
Divis			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Locatio City or	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
}	To the within 2 To the complete	Σ	29b. Signature and the of certifier on a	29c. License number	29d. Date signed (Month, Day, Year) OCTOBER 09 20	-6.		
_	m		30. Name and address of person who completed cause of death (Item 23a) (Type, AVVERALLI LARISH."	Print) NORTHWEST 100SC 5401 OLD COVE	TROAP MDD	1133-		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 2 2004 32. Registrar's Signature	Spack				